

the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14298

CERTIFICATE OF DEATH

Reg. Dist. No. 14190

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roger Heights Md		c. LENGTH OF STAY IN 1b 29 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5309 Emerson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeremiah		4. DATE OF DEATH Month Dec Day 14 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1882
9. AGE (In years lost birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintance		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Babylon		14. MOTHER'S MAIDEN NAME Julia Boose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Margaret Babylon		Address Roger Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cardiac disease DUE TO (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 19 60 , to Dec 14 , 19 60 , that I last saw the deceased alive on Dec 14 , 19 60 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis M. Jimal		ADDRESS (Street, city or town, state) Cottage City, Md. DATE SIGNED 12-15-60	
PHYSICIAN'S NAME (Type) Louis Jimal		Cottage City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE DEC 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14227

14191

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Agnes Beall				4. DATE OF DEATH Month Day Year 12-13-60			
5. SEX Fe.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-31-98	
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) yrs. 62		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Forestville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wiley Sansbury				14. MOTHER'S MAIDEN NAME Katherine Mae Kraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Richard E. Beall, 5710 Allentown Rd, Camp Springs Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO Adenocarcinoma of left breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-12-1960 to 12-13-1960 , that (I) (we) last saw the deceased alive on 12-13-1960 , and that death occurred at 11:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Charles David Connors, M.D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 12-13-60			
22c. PHYSICIAN'S NAME (Type) Dr. Charles David Connors, M.D.				22d. ADDRESS 5813 Landover Road, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Chamber Co Riverdale Md. ADDRESS				25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14192											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park					
c. LENGTH OF STAY IN 1b 40 years						d. STREET ADDRESS 16519-C Street					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6519-C Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Robert Luther Bell						4. DATE OF DEATH Nov 26 1960					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13 1899		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer				10b. KIND OF BUSINESS OR INDUSTRY Merchandising				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.-C	
13. FATHER'S NAME William Benjamin Bell						14. MOTHER'S MAIDEN NAME Mary Elizabeth King					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 578-48-2235		17. INFORMANT Mrs Sarah V Bell		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Nov 26, 1960					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-31-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				22d. LOCATION (City, town, or country) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR W. W. Chamber E. 517-11th St. S.E.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
						DATE DEC 29 '60					

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14193

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b Dead on arrival Greenbelt d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 67 d. STREET ADDRESS 20 C Parkway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Herman Boomhower				4. DATE OF DEATH Month Day Year December 28 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1908		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Boomhower				14. MOTHER'S MAIDEN NAME Helen Boomhower					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 11				16. SOCIAL SECURITY NO. 577-24-1559		17. INFORMANT Mary M Boomhower, Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) coronary arteriosclerosis Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (c) 420.1								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)				M.D. James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co. Funeral Home, Md.				24a. REC'D BY REGISTRAR JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kane			

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dept. of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

11308 MEDICAL INQUIRY REPORT OF DEATH

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January 20, 1940

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June 1, 1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
14229 CERTIFICATE OF DEATH 14154										
1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>8Hrs 55 Min 35</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>					d. STREET ADDRESS <u>1209 69th Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Boyd</u> Last <u>Boyd</u>			4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>19 60</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Color</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 8/1960</u>		9. AGE (In years lost birthday) yrs. <u>8</u> 55		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Lorenzo Boyd</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Cooper</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mother</u>			Address <u>Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (3 lbs)</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Probable intracranial Hemorrhage</u> DUE TO (c) <u>Atelectasis</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 9</u> 19 <u>60</u> to <u>Dec. 9</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 9</u> 19 <u>60</u> and that death occurred on <u>Dec 9</u> 19 <u>60</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Thomas A. Christensen</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/9/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas A. Christensen, M.D.</u>					22d. ADDRESS <u>6905 Baltimore Ave., College Park, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp Cheverly, Maryland</u>			23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY W. PENN, Jr</u>					ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JAN 6 '61</u>										

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CERTIFICATE OF DEATH

Reg. Dist. No. 14195

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicville - Box 174</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904 564 Ave.</u>		d. STREET ADDRESS <u>18X-2</u>	
3. NAME OF DECEASED (Type or print) <u>Hattie</u> First <u>Boyd</u> Middle <u>Boyd</u> Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nick Dorney</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1725-3111111111</u>	
17. INFORMANT <u>Marie Harris</u>		Address <u>1725-3111111111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>9-28-</u> , 1960, to <u>12-3-</u> , 1960, that I last saw the deceased alive on <u>12-1-</u> , 1960, and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson</u> , M.D.		ADDRESS (Street, city or town, state) <u>1001 Eastern Ave. N.E.</u> DATE SIGNED <u>12-3-60</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		<u>Washington 27, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>	22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Faus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

CLASS OF DEATH (1) Natural (2) Accidental (3) Suicide (4) Homicide (5) Undetermined		PLACE OF DEATH (1) Home (2) Hospital (3) Prison (4) Other	
SEX (1) Male (2) Female		AGE (1) Under 1 (2) 1-4 (3) 5-9 (4) 10-14 (5) 15-19 (6) 20-24 (7) 25-29 (8) 30-34 (9) 35-39 (10) 40-44 (11) 45-49 (12) 50-54 (13) 55-59 (14) 60-64 (15) 65-69 (16) 70-74 (17) 75-79 (18) 80-84 (19) 85-89 (20) 90-94 (21) 95-99 (22) 100+	
RACE (1) White (2) Negro (3) Other		OCCUPATION (1) Professional (2) Managerial (3) Clerical (4) Service (5) Unemployed (6) Other	
MARITAL STATUS (1) Single (2) Married (3) Widowed (4) Divorced		EDUCATION (1) Less than High School (2) High School (3) Some College (4) College Graduate (5) Postgraduate	
PLACE OF BIRTH (1) Maryland (2) Other State (3) Foreign		DATE OF BIRTH (1) 1900-1909 (2) 1910-1919 (3) 1920-1929 (4) 1930-1939 (5) 1940-1949 (6) 1950-1959 (7) 1960-1969 (8) 1970-1979 (9) 1980-1989 (10) 1990-1999	
DATE OF DEATH (1) 1900-1909 (2) 1910-1919 (3) 1920-1929 (4) 1930-1939 (5) 1940-1949 (6) 1950-1959 (7) 1960-1969 (8) 1970-1979 (9) 1980-1989 (10) 1990-1999		TIME OF DEATH (1) 12:00-1:00 (2) 1:00-2:00 (3) 2:00-3:00 (4) 3:00-4:00 (5) 4:00-5:00 (6) 5:00-6:00 (7) 6:00-7:00 (8) 7:00-8:00 (9) 8:00-9:00 (10) 9:00-10:00 (11) 10:00-11:00 (12) 11:00-12:00	
CAUSE OF DEATH (1) Heart Disease (2) Cancer (3) Stroke (4) Diabetes (5) Kidney Disease (6) Liver Disease (7) Lung Disease (8) Infection (9) Injury (10) Poisoning (11) Other		MANNER OF DEATH (1) Natural (2) Accidental (3) Suicide (4) Homicide (5) Undetermined	
SIGNATURE OF DECEASED (1) Signature (2) Initials (3) None		SIGNATURE OF WITNESS (1) Signature (2) Initials (3) None	
SIGNATURE OF PHYSICIAN (1) Signature (2) Initials (3) None		SIGNATURE OF CORONER (1) Signature (2) Initials (3) None	
SIGNATURE OF JUDGE (1) Signature (2) Initials (3) None		SIGNATURE OF CLERK (1) Signature (2) Initials (3) None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14301

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14196

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Col.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Andrews A.F.B. Hospital</u>				d. STREET ADDRESS <u>5207 Canterbury Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Bracke</u> Last <u>Bracke</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 Dec. 1960</u>	
9. AGE (In years lost birthday) <u>30</u>		IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> Hours <u>30</u>		IF UNDER 24 HRS. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter P. Bracke</u>				14. MOTHER'S MAIDEN NAME <u>Eloise Metz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>76210</u> IMMEDIATE CAUSE (a) <u>FETAL ANOXIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7 Dec 1960</u> , to <u>7 Dec 1960</u> , that (I) (we) lost saw the deceased alive on <u>7 Dec 1960</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Nicholas P. Haritos</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7 Dec 60</u>	
22c. PHYSICIAN'S NAME (Type) <u>NICHOLAS P HARITOS, CAPT USAF MC</u>				22d. ADDRESS <u>USAF HOSP, ANDREWS AFB, WASH 25, DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>D. C. Morgue</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>--</u>				ADDRESS <u>--</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 13 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haritos</u>	

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13301

CERTIFICATE OF DEATH

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UNITED STATES DEPARTMENT OF HEALTH

AND HUMAN SERVICES

FORM NO. 100-1

REVISED 1-7-60

U.S. GOVERNMENT PRINTING OFFICE

16-70801-1

FOR SALE BY THE

GOVERNMENT

PRINTING OFFICE

WASHINGTON, D.C.

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may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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News

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14230

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Highland Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1202 69th Pl.			
3. NAME OF DECEASED (Type or print) Baby Girl "B" Britt				4. DATE OF DEATH Month Dec. Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Dec. 1960	
9. AGE (In years last birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 9		IF UNDER 24 HRS. Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Leon T/ Britt				14. MOTHER'S MAIDEN NAME Barbara Ann Mc Clurkin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Prematurity (2 lbs 6 oz) DUE TO (b) Electrolysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 12 1960 to Dec. 6 1960 , that (I) (we) last saw the deceased alive on Dec. 6 1960 and that death occurred at 2:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Thomas A. Christensen				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/6/60	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.				22d. ADDRESS 6905 Baltimore Ave. College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1/4/61		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				ADDRESS Cheverly, Md.		25a. REC'D BY REGISTRAR JAN 6 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

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CENTRAL INTELLIGENCE AGENCY

MEMORANDUM

TO : DIRECTOR, CENTRAL INTELLIGENCE AGENCY

FROM : [Illegible]

SUBJECT : [Illegible]

DATE : [Illegible]

1. [Illegible]

2. [Illegible]

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61. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP AT5 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14231

CERTIFICATE OF DEATH

14198

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 2712 Webster St.		
3. NAME OF DECEASED (Type or print) First Theodore Middle G. Last Buehler			4. DATE OF DEATH Month Dec. Day 11 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1901		9. AGE (In years lost birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Wash. Bldg.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Robert Buehler			14. MOTHER'S MAIDEN NAME Daisy Grice		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 578-24-4282		
17. INFORMANT Lucille Buehler			2712 Webster St. Mt. Rainier, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. UNEMIA 2. Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH 7 days 5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 19 57 to Dec 11 19 60 , that (I) (we) last saw the deceased alive on Dec 11 19 60 and that death occurred at 11:20 AM , from the causes and on the date stated above.					
22a. SIGNATURE Norman Donat Comenu			22b. DATE SIGNED 12/11/60		
22c. PHYSICIAN'S NAME (Type) Norman Donat Comenu			22d. ADDRESS 3503 Pennysr Mt Rainier Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.					
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company			25. REC'D BY REGISTRAR DEC 13 '60		
25b. REGISTRAR'S SIGNATURE					

14281

CENTRAL OF DEATH

[Faint, mostly illegible text covering the majority of the page, appearing to be a form or document with multiple lines of text.]

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
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VR A15 (4)
15M 9/59

14232

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14193

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W Last Buffington		4. DATE OF DEATH Dec. 27 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-88
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY U S Government	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John E Buffington	
14. MOTHER'S MAIDEN NAME Agnes A Garber		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Grace L Buffington College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerotic Cardio-Vascular DUE TO Penal Disease & Anemia (b) Diabetes Mellitus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/22/60 to 12/27/60 , that (I) (we) last saw the deceased alive on 12/26/60 , and that death occurred at A M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Wolcott L Etienne M.D.		22b. DATE SIGNED 12/27/60	
22c. PHYSICIAN'S NAME (Type) Dr. Wolcott L Etienne, M.D.		22d. ADDRESS 4713 Berwyn Rd., College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 29, 1960	23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery	23d. LOCATION (City, town, or county) (State) Taneytown Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE DEC 30 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Travis	

14503

CENTRAL BANK OF INDIA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14200

14302

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Lewisdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2200 Beechwood Road</u>				d. STREET ADDRESS <u>6200 Beechwood</u>			
3. NAME OF DECEASED (Type or print) <u>CATHERINE MAGDELINE CALLAHAN</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reith</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Arthur E. Callahan, Jr. (Same as #2)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>3 YEARS</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>58</u> , to <u>12/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hugh W. Ireby</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7105 - Riggs Rd., Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>HUGH W IREY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward M. Miller</u> ADDRESS <u>254 Carroll St. NW. DC</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

CERTIFICATE OF DEATH

14233

Dr. J. J. J. J.

CHERRYHILL, N.J.

Dr. J. J. J. J.

MARY

O

CHERRYHILL, N.J.

Dr.

1911-12

White

Medical

Medical

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1911-12

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1911-12-12

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1911-12-12

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14296

CERTIFICATE OF DEATH

Reg. Dist. No. 456

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 19 Morningside	
c. LENGTH OF STAY IN 1b 7 Mos.		d. STREET ADDRESS #1 Beauford Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #1 Beauford Rd.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle HELEN Last CHANEY		4. DATE OF DEATH DEC. 30 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1893
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stamp		14. MOTHER'S MAIDEN NAME -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Ruth Jennings-Same As Item #2.		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE VENTRICULAR TACHYCARDIA DUE TO 422.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO 4 YRS. + (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Thrombosis Aug. 1956 + Oct. 1960			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC. 7, 1960 , to DEC. 30, 1960 , that I last saw the deceased alive on DEC. 30, 1960 , and that death occurred at 11:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE WUB Sheer		ADDRESS (Street, city or town, state) 7200 MARLBORO PKE	
PHYSICIAN'S NAME (Type) WALTER R. SHEER M.D. WASH. 28, D.C.		DATE SIGNED 12-30-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/61	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro,		ADDRESS Md.	
24a. REC'D BY REGISTRAR JAN 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14216

CERTIFICATE OF DEATH

Reg. Dist. No. 14202

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5413 20th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel A. Chepuras		4. DATE OF DEATH Month 12 Day 4 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Produce	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholes Chepuras		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rev. John T. Tavlardies		Address 2732 Porter St Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days + 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov , 19 60 , to Dec 4 , 19 60 , that I last saw the deceased alive on Dec 4 , 19 60 , and that death occurred at 9:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo Jr.		ADDRESS (Street, city or town, state) 3501 Hamilton St Hyts DATE SIGNED 12/4	
PHYSICIAN'S NAME (Type) Frank M. Trozzo, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/60	22c. NAME OF CEMETERY OR CREMATORY Glenwood cemetery, DC	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		24. REC'D BY REGISTRAR DEC 6 '60	
ADDRESS 2901 14th St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>10-15-1918</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>[Signature]</u></p>	
<p>8. Signature of registrar: <u>[Signature]</u></p>	
<p>9. Date of registration: <u>10-16-1918</u></p>	
<p>10. Place of registration: <u>Boston</u></p>	
<p>11. Name of registrar: <u>[Name]</u></p>	
<p>12. Name of physician: <u>[Name]</u></p>	
<p>13. Name of informant: <u>[Name]</u></p>	
<p>14. Name of informant: <u>[Name]</u></p>	
<p>15. Name of informant: <u>[Name]</u></p>	
<p>16. Name of informant: <u>[Name]</u></p>	
<p>17. Name of informant: <u>[Name]</u></p>	
<p>18. Name of informant: <u>[Name]</u></p>	
<p>19. Name of informant: <u>[Name]</u></p>	
<p>20. Name of informant: <u>[Name]</u></p>	
<p>21. Name of informant: <u>[Name]</u></p>	
<p>22. Name of informant: <u>[Name]</u></p>	
<p>23. Name of informant: <u>[Name]</u></p>	
<p>24. Name of informant: <u>[Name]</u></p>	
<p>25. Name of informant: <u>[Name]</u></p>	
<p>26. Name of informant: <u>[Name]</u></p>	
<p>27. Name of informant: <u>[Name]</u></p>	
<p>28. Name of informant: <u>[Name]</u></p>	
<p>29. Name of informant: <u>[Name]</u></p>	
<p>30. Name of informant: <u>[Name]</u></p>	
<p>31. Name of informant: <u>[Name]</u></p>	
<p>32. Name of informant: <u>[Name]</u></p>	
<p>33. Name of informant: <u>[Name]</u></p>	
<p>34. Name of informant: <u>[Name]</u></p>	
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<p>59. Name of informant: <u>[Name]</u></p>	
<p>60. Name of informant: <u>[Name]</u></p>	
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<p>80. Name of informant: <u>[Name]</u></p>	
<p>81. Name of informant: <u>[Name]</u></p>	
<p>82. Name of informant: <u>[Name]</u></p>	
<p>83. Name of informant: <u>[Name]</u></p>	
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<p>94. Name of informant: <u>[Name]</u></p>	
<p>95. Name of informant: <u>[Name]</u></p>	
<p>96. Name of informant: <u>[Name]</u></p>	
<p>97. Name of informant: <u>[Name]</u></p>	
<p>98. Name of informant: <u>[Name]</u></p>	
<p>99. Name of informant: <u>[Name]</u></p>	
<p>100. Name of informant: <u>[Name]</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

14303

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14203

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C., N.W. 47X-3	
d. STREET ADDRESS 419 - Kennedy St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle L. Last Clark		4. DATE OF DEATH Month 12 Day 11 Year 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/22/83	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeping		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lucas Clark		14. MOTHER'S MAIDEN NAME Sara Rollins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ? (card lost)	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420-0 Arteriosclerotic heart disease with coronary insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Duration unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis; bronchopneumonia, right middle lobe, resolving; pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/9 11:45 19 60 to 12/11 19 60 , that (I) (we) last saw the deceased alive on 12/11/1960 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/11/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-13-60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Champeau Co		25a. REC'D BY REGISTRAR DEC 19 '60	
ADDRESS 517-11th St S.E.		25b. REGISTRAR'S SIGNATURE Arthur S. Pines	

1-2303

DEPARTMENT OF DEATH

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14304

CERTIFICATE OF DEATH

Reg. Dist. No. 14204

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN lb 8 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Largo Rd. RFD Box 2771		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle L Last CLARKE, SY		4. DATE OF DEATH Month DEC Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chrmn of Board		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Supply Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry F. Clarke		14. MOTHER'S MAIDEN NAME Carolyn Barline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO UNKN		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Marie A. Clarke-Same as above		Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CVR Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 60 , to 20 Mar , 19 60 , that I lost saw the deceased alive on 20 Mar , 19 60 , and that death occurred at 5:45 AM , from the causes and on the date stated above. DATE SIGNED Upper Marlboro, Md 12/20/60			
ACTUAL SIGNATURE Robert B. Sasscer		M.D. Upper Marlboro, Md	
PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/22/60	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro		24a. REC'D BY REGISTRAR DATE JAN 3 '61	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Charles E. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corob papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

14234

CERTIFICATE OF DEATH

14205

Item 2 Film 6277 12-21-60 et

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntsville/ Highland Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 6209 "M" Street 118 P Street, S.W., Wash., D.C.	
3. NAME OF DECEASED (Type or print) First Asbury Middle Codkrell Last Codkrell		4. DATE OF DEATH Month Dec. Day 6 Year 19 60	
5. SEX male female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1892 1892-04-12
9. AGE (In years lost birthday) yrs. 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	
11. BIRTHPLACE (State or foreign country) Lettsburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anious Cockrell		14. MOTHER'S MAIDEN NAME Ann Cockrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Howard Cockrell	
17. INFORMANT Howard Cockrell		Address 118 P St., S.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 792X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 27 , 19 60 , to Dec. 6 , 19 60 , that (I) (we) last saw the deceased alive on Dec. 6 , 19 60 , and that death occurred on Dec. 6 , 19 60 , at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Fredrick B. Brandt		22b. DATE Dec 7, 1960	
22c. PHYSICIAN'S NAME (Type) Dr. Fredrick B. Brandt, M.D.		22d. ADDRESS 1726 Eye St NW.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-10-60-BURIAL		23b. DATE THEREOF 12-10-60	
23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town, or county) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines Co.		25a. REC'D BY REGISTRAR DEC 12 1960	
ADDRESS 3015-12th St. N.E.		25b. REGISTRAR'S SIGNATURE Robert L. Plummer, Director	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14235
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14206

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 36			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 9102 7th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARL Middle F. Last COOLEY SR				4. DATE OF DEATH Month 12 - Day 30 - Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1915	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min.		11. IF UNDER 24 HRS. Months 45 Days 45 Hours 45 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Goetz Meats Co. Va			
11. BIRTHPLACE (State or foreign country) Va				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank S Cooley				14. MOTHER'S MAIDEN NAME Mamie F. Rudolph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT Eleanor S Cooley				Address 9102 7th St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Myocardial infarct - anterior L. Ventricle DUE TO (c) 3. Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 60 , to 12/30 , 19 60 , that (I) (we) last saw the deceased alive on Dec. 30 , 19 60 , and that death occurred at 9:15 M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick E. Musser				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/30/60	
22c. PHYSICIAN'S NAME (Type) Dr. Frederick E. Musser				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-2-61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Great Funeral Home				ADDRESS 4812 90. Ave. NW Wash. DC.		25a. REC'D BY REGISTRAR DATE JAN 4 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CELESTIAL DEATH

1453

James George ...

Marion

John ...

James

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 Seat Pleasant d. STREET ADDRESS 6900 George Palmer Highway	
3. NAME OF DECEASED (Type or print) Frank Taylor Cope		4. DATE OF DEATH December 4, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Jan. 9, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Abner Lee Cope		14. MOTHER'S MAIDEN NAME Zora Belle Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 579-03-8130	
17. INFORMANT Mrs Ann S Cope, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR W.W.Chambers Co. 3072 M St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DEC 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kenna		DATE	

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Prince George's

Montford

Prince George's

Boat Hospital

J. O. A.

Quarry

6900 George Highway

Prince George's General Hospital

60

December

June

May

June

63

Jan. 9, 1907

2

White

Male

U. S. A.

Tennessee

Heart

Interior

John L. L. L. L.

James Lee Cook

June 2, 1907

77-2-2100

MI

Lee

Acute congestive heart failure

Chronic colitis and disease

X

X

X

12/4/00

X

James I. Cook

Washington, D.C.

Washington National

12/7/00

Medical

United States

June 2, 1907

W. L. Chambers, Co. 30th M. S. N. Y. Regt. U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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14305
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CAMP SPRINGS		c. LENGTH OF STAY IN 1b LESS THAN 4 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL Andrews		d. STREET ADDRESS 1 BOX 301 RT. 2.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SHIRLEY First JEAN Middle CORRELL Last		4. DATE OF DEATH Month DEC Day 24 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 60
9. AGE (In years lost birthday) — yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 4 Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RODERICK L.		14. MOTHER'S MAIDEN NAME SHIRLEY JEAN WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) N/A (If yes, give year or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT SHIRLEY J CORRELL (Mother)		Address Box 301 Rt 2 Clinton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningococcemia DUE TO 057.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH ? 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 Dec 1960 , to 24 Dec 1960 , that (I) (we) last saw the deceased alive on 24 Dec 1960 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE John A. Moore		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN A. MOORE		22d. ADDRESS USAF Hsp, Andrews Air Force Base	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/60	
23c. NAME OF CEMETERY OR CREMATORY Conkle Fun'l Home, Indianapolis, Ind.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi		25a. REC'D BY REGISTRAR DEC 27 '60	
ADDRESS 816 H St., NE, Wash., DC		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14217

CERTIFICATE OF DEATH

14209

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 Lp Lake Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS DESALES COX</u>		4. DATE OF DEATH Month Day Year <u>December 3 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1877</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 24</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEVER EMPLOYED</u>		12. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
13. FATHER'S NAME <u>John F. Cox</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE V. WELCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Sister Agnes Patricia O. Carr 4922 Lp Lake Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac and respiratory failure</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Carcinoma of the heart with mural and lung metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>30 minutes</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive and atherosclerotic cardiovascular disease.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>June 1960</u> to <u>December 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>December 3, 1960</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph J. McCarthy, Jr.</u>		22b. DATE SIGNED <u>DEC. 3, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH J. MCCARTHY, JR., M.D.</u>		22d. ADDRESS <u>3001 Q ST. N.W. WASHINGTON D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-6-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. DeVol</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

14237^{DN}

14210

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George's		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Ann Crocker		4. DATE OF DEATH 12 21 1960	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-1888	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Aaron Newcombe		14. MOTHER'S MAIDEN NAME 2 Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT George H Crocker, Kent Village, Prince George's		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute cardiac failure DUE TO (b) Arteriosclerotic coronary disease DUE TO (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1 1960 to Dec 21 1960 that (I) (we) last saw the deceased alive on Dec 21 1960 and that death occurred at 8 PM, from the causes and on the date stated above.			
22a. SIGNATURE Peter Dumas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) PETER DUMAS		22d. ADDRESS 6124 Central Ave Capitol Heights, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/23/69		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Randolph Cem.		23d. LOCATION (City, town, or county) (State) Randolph Wis.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee Sons Co		25a. REC'D BY REGISTRAR DATE DEC 27 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

11237

[Faint, illegible text, likely a contract or legal document]

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[Circular stamp]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14306

CERTIFICATE OF DEATH

Reg. Dist. No. 14211

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover P.O.				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9202 Ardmore Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE VIRGINIA DENHAM				4. DATE OF DEATH Month Day Year December 11th, 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25th, 1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Sanford				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address George V. Denham, 9202 Ardmore Rd. Landover P.O. M.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabete Mellitus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Gangerene Right Foot							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1946, to Dec. 11th, 1960, that I last saw the deceased alive on Dec. 10th, 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1024 Mass. Ave., N.E. 12/11/1960 Washington, D.C.							
ACTUAL SIGNATURE Frederick W. Schneider		PHYSICIAN'S NAME (Type) Frederick W. Schneider					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/1960		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR DATE DEC 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14238

14212

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle DOUGLAS Last DOUGLAS				4. DATE OF DEATH Month Dec Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 8, 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) yrs. 1 Months 3 Days 3		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Nelson Brown				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				14. MOTHER'S MAIDEN NAME Mary Alice Douglas		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)				17. INFORMANT Hospital Records Address			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/11/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/13/60		22c. NAME OF CEMETERY OR CREMATORY John Wesley Meth.		22d. LOCATION (City, town, or country) (State) Aguasco, Maryland	
23. FUNERAL DIRECTOR George H. Nelson ADDRESS Aguasco, Md.				24a. REC'D BY REGISTRAR DEC 19 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

VS. A15ME
5M 7/59

Novo

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Three days

Abstract

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572

Prince George Hotel Building

1502

Nov 4 1960

3102

Analyses

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X
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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14307

CERTIFICATE OF DEATH

Reg. Dist. No.

14213

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1207-58th Ave.</u>		d. STREET ADDRESS <u>1207-58th Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>-</u> Last <u>DVORAK</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1869</u>
9. AGE (In years lost birthday) <u>91</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>(?) VANERKA</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u> HANNAH <u>(?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>CHAS W Dvorak - 1207-58th Ave, Hillside, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 24, 1960</u> to <u>December 4, 1960</u> , that I last saw the deceased alive on <u>December 4, 1960</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		ADDRESS (Street, city or town, state) <u>6124 Central Ave</u> DATE SIGNED <u>12/4/60</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Hill Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/7/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>FRESH POND CREMATORIAL</u>		22d. LOCATION (City, town, or county) <u>Middle Village N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Fimerac Hon.</u>		ADDRESS <u>300 74th St NE</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

14407

CENTRAL RECORDS

1940-1941

1940-1941

MAY

1940-1941

1940-1941

1940-1941

1940-1941

1940-1941

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1940-1941

1940-1941

1940-1941

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1940-1941

1940-1941

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14214

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Brentwood</u> c. LENGTH OF STAY IN 1b <u>30 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4550 41st Avenue</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Brentwood</u> d. STREET ADDRESS <u>14550-41st Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John Alexander Hoyer</u> First Middle Last			4. DATE OF DEATH <u>Dec 13 1960</u> Month Day Year		
5. SEX <u>male</u> 6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 30, 1872</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Alexander Hoyer</u> 14. MOTHER'S MAIDEN NAME <u>Ida Elizabeth Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>17-52-1000 ST NW</u> 17. INFORMANT <u>Arthur Hoyer, Washington DC</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-13-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-17-60</u> 22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Harmony Home Park Md.</u> 22d. LOCATION (City, town or country) (State)		23. FUNERAL DIRECTOR <u>Distict mortician funeral home</u> ADDRESS <u>1900 17th Ave. NW</u>	
24a. REC'D BY REGISTRAR <u>H98</u> 24b. REGISTRAR'S SIGNATURE <u>John R. Watson</u>		DEC 16 '60			

INVESTIGATIVE DIVISION
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

DATE
PAGE

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10-10-68
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CERTIFICATE OF DEATH

Reg. Dist. No.

14215

14309

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Adelphi		c. LENGTH OF STAY IN 1b 1 yr. 4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 47			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home				d. STREET ADDRESS 3710 36th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida Ellen Edloff		First Middle Last		4. DATE OF DEATH Dec. 20 1960		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 5, 1876		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Randolph Kusby				14. MOTHER'S MAIDEN NAME Anne Hailer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 47 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-12-1960, to 12-21-1960, that I last saw the deceased alive on 12-20-1960, and that death occurred at 2:50 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stuart L. Nelson				ADDRESS (Street, city or town, state) DATE SIGNED 7600 Carroll Ave Takoma Park 12-21-60			
PHYSICIAN'S NAME (Type) Stuart L. Nelson, M.D.				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kallay's Funeral Home		ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14

REPORT OF THE

COMMISSIONER OF

THE LAND OFFICE

FOR THE YEAR

1893

ALBANY:

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W. H. BROWN,

PRINTED BY

THE STATE

PRINTING OFFICE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14291

CERTIFICATE OF DEATH

Reg. Dist. No. 14216

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY D. of Columbia ✓ b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47X	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL adm. 7-15-1951		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 1865 WYOMING AVE. N.W.	
3. NAME OF DECEASED (Type or print) First MAUDE Middle ENDICOTT Last ENDICOTT		4. DATE OF DEATH Month 12 Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-1873
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	11. BIRTHPLACE (State or foreign country) NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME M. T. ENDICOTT	
14. MOTHER'S MARRIED NAME ELISABETH ADAMS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hosp. Records Laurel Sanitarium Address Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neurovascular DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 446X DUE TO (c) 446X		INTERVAL BETWEEN ONSET AND DEATH many yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with Dementia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6, 1956 to 12-6-1960 that I last saw the deceased alive on 12-6-1960 , and that death occurred at 5:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. P. Kraemer		DATE SIGNED 12-6-60	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		ADDRESS Laurel Maryland	
22a. CREMATION, BURIAL, OR OTHER DISPOSITION (Specify) CREMATION		22b. DATE THEREOF 12-7-1960	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		22d. LOCATION (City, town, or county) (State) SUITLAND, PRINCE GEORGE, Md/	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Sawyers Sawyers ADDRESS 1756 Pq. Ave. N.W.		24a. REC'D BY REGISTRAR DEC 8 '60	
24b. REGISTRAR'S SIGNATURE C. S. Kraemer			

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14239

14217

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Faircloth		4. DATE OF DEATH Dec. 6 19 60	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Dec. 1960
9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon C Faircloth		14. MOTHER'S MAIDEN NAME Mattie Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mother	
17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (1 lbs 12 oz) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abnormal pulmonary ventilation DUE TO (c) Asphyxia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 4 19 60 to Dec. 6 19 60 , that (I) (we) lost saw the deceased alive on Dec. 6 19 60 , and that death occurred at 7:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Christensen M.D.		22b. DATE SIGNED 12/6/60	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas A Christensen, M.D.		22d. ADDRESS 6905 Baltimore Ave. College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1/4/61	
23c. NAME OF CEMETERY OR CREMATORY Prince Georges Southern P		23d. LOCATION (City, town, or county) (State) Chesley Md	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W Penn		25. REC'D BY REGISTRAR DATE JAN 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

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CERTIFICATE OF DEATH

14230

IT BEING HEREBY CERTIFIED THAT THE ABOVE NAMED DECEASED PERSON WAS

DECEASED AT THE PLACE AND ON THE DATE AND AT THE AGE OF YEARS

AND THAT THE DECEASED PERSON WAS AT THE TIME OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14310

14218

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4635 - Lacy Ave., S. E.				d. STREET ADDRESS 4635- Lacy Ave., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES First F. Middle FERRALL Last				4. DATE OF DEATH Dec. 9th. Month 1960 Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15th 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Naval Weapons Plant		11. BIRTHPLACE (State or foreign country) St. Mary's Co, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Ferrall				14. MOTHER'S MAIDEN NAME Susan Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Minnie A. Ferrall				Address Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Bronchopneumonia 4500 DUE TO (b) Senile General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) —							
INTERVAL BETWEEN ONSET AND DEATH 10 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 — p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 1 19 60 to Dec 9 19 60 that (I) we last saw the deceased alive on Dec 8 19 60 , and that death occurred at 7:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Paul C Van Natta				22b. DATE SIGNED Dec 9 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Paul O. Van Natta				22d. ADDRESS 5440- Silver Hill Road, Parkland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				ADDRESS 1661- Good Hope Rd. S.E. Washington, DC		25a. REC'D BY REGISTRAR DEC 12 '60	
				25b. REGISTRAR'S SIGNATURE —			

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14240

CERTIFICATE OF DEATH

14219

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Chillum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 1 1840 Longford Drive	
3. NAME OF DECEASED (Type or print) First George Middle A. Last Fillah		4. DATE OF DEATH Month December 18 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) SYRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unk. SERTUTE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-24-7584	
17. INFORMANT Address MICHAEL FILLAH (Son) 2d-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-4-24 X DUE TO Wemic Coma (b) Arterio-sclerotic hypertension (c) Cardio renal disease DUE TO lying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-22-1960 to 12-18-1960, that (I) (we) last saw the deceased alive on 12-18-1960, and that death occurred at 3:45P from the causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 12-19-60	
22c. PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D.		22d. ADDRESS 3717 38th Ave., Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 21, 1960	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) BLADENSBURG MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 23 '60	
ADDRESS 816 Hst Wt Annapolis		25b. REGISTRAR'S SIGNATURE Anthony S. Hanna	

CERTIFICATE OF DEATH

11540

27 days



14292

CERTIFICATE OF DEATH

Reg. Dist. No. 14220

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm. 5-3-57</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JEANNETTE H. FOSSETT</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELIAZAR HODGEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA VIRGINIA SCOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>12-03-0683A</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion (420.i)</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>many yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LAUREL SANITARIUM</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-3</u> , 19 <u>57</u> to <u>12-15</u> , 19 <u>60</u> that I last saw the deceased alive on <u>12-15</u> , 19 <u>60</u> , and that death occurred at <u>6:15</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Kucum</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>12-15-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mitchell</u> ADDRESS <u>1900 Eastern Ave. Balto. 17, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
14311
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14221

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
4. DATE OF DECEASED (Type or print) Elizabeth Gaines		4. DATE OF DEATH Month 12 Day 22 Year 1960	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/91	
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fielding Gaines		14. MOTHER'S MAIDEN NAME Ann Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. lost	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of gall bladder with metastases 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/23/60 to 12/22/60, that (I) (we) last saw the deceased alive on 12/22/60, and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/22/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12/27/60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Bethel Church Cemetery		23d. LOCATION (City, town, or county) Alex. VA. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Thompson #24		25a. REC'D BY REGISTRAR DATE DEC 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Thompson			

CERTIFICATE OF DEATH

1931

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14312

14222

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE CALIFORNIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN LUIS OBISPO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP, ANDREWS AFB, WASH 25, DC				d. STREET ADDRESS 1105 LEFT STREET 43X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		JAMES		WALTER		GARVIN	
4. DATE OF DEATH		Month		Day		Year	
		DECEMBER		23		19 60	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10 JULY 1936		24 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY US ARMY		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JAMES G GARVIN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. APR 60-Present		17. INFORMANT MEDICAL RECORDS & PERSONNEL RECORDS			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intercranial hemorrhage 978X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull fracture DUE TO (c) R							INTERVAL BETWEEN ONSET AND DEATH 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Punctured liver, spleen, both top ribs fractured, separation of kidney							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient apparently jumped out of 4th floor window --SUICIDE					
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. DEC 23 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOSPITAL		20f. (City or town) (County) (State) USAF HOSP ANDREWS WASH 25 DC	
21. I certify that (I) (this hospital) attended the deceased from 23 Dec 1960 to 23 Dec 1960 , that (I) (we) last saw the deceased alive on 23 DEC 1960 , and that death occurred at 4:50A from the causes and on the date stated above.							
22a. SIGNATURE Gerald Resner				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 23 DEC 60	
22c. PHYSICIAN'S NAME (Type) GERALD RESNER, Capt USAF (MC)				22d. ADDRESS USAF HOSP, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Godsman Fun'l Hm, San Francisco, Calif.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi				25a. REC'D BY REGISTRAR DEC 28 '60		25b. REGISTRAR'S SIGNATURE Arthur J. Knease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1913

STATE OF NEW YORK

County of _____

City of _____

On the _____ day of _____

at _____

14241

CERTIFICATE OF DEATH

Reg. Dist. No. 14223

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.C.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>37 1/2 - Bladensburg Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Christian R. Gates</u>		4. DATE OF DEATH <u>12-17-1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR <u>66</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Cornelius Gates</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Marie Hooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-01-2559</u>	
17. INFORMANT <u>Charlotte A. Testard, Sister</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Innervation</u> DUE TO (c) <u>Gastric resection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>53</u> to <u>July 10</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1 Oct</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Thompson</u>		DATE SIGNED <u>12/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles W. Thompson, M.D., 1726 M Street, N.W., Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		24. REC'D BY REGISTRAR <u>DEC 22 '60</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF COST

14541

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[Faint, mostly illegible text follows, appearing to be a form with multiple sections and lines of text.]

14218

CERTIFICATE OF DEATH

Reg. Dist. No.

14224

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4014 Hamilton St.		d. STREET ADDRESS 4014 Hamilton st	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah Medford Gemmill		4. DATE OF DEATH Dec 19 1960	
5. SEX fem	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1873
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		11. BIRTHPLACE (State or foreign country) Chestertown, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Sutton Gemmill		14. MOTHER'S MAIDEN NAME Margaret Susan Rasin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish American War		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs R.S. Bulgians 4014 Hamilton Hyattsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with 332x DUE TO at Sphenophlegia (progenus) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen Arteriosclerosis - Hypertension. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 12/4/60.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/19/1960, to 12/19/1960, that I last saw the deceased alive on 12/19/1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 12/19/60	
ACTUAL SIGNATURE Howard T. Morse		M.D. 2034 Carroll Ave	
PHYSICIAN'S NAME (Type) Howard T. Morse		Tehoma Park Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/60	22c. NAME OF CEMETERY OR CREMATORY I U Church Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE DEC 22 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
14225									
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village d. STREET ADDRESS 7323 Forest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Julie Ann Giblin			4. DATE OF DEATH December 13 1960						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1936		9. AGE (In years last birthday) 24 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Frank J. Chmieleir					14. MOTHER'S MAIDEN NAME Helen Townsend				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas E. Giblin,		Address Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Tracheobronchitis and Bilateral Pneumonitis 501X Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) } 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/60		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or country) (State) Iowa City, Iowa.			
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR DEC 19 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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Page 1 of 2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14243
14226
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Edward Gray				4. DATE OF DEATH Month Day Year December 25 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1900	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Porter				10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal Co. Bowie Md.			
13. FATHER'S NAME Hezikiah Gray				14. MOTHER'S MAIDEN NAME Martha Shorter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Daniel Gray				Address 2827 11th St. NW. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hematoma 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 30 19 60 to Dec. 25 19 60, that (I) (we) lost saw the deceased alive on Dec. 25 19 60 and that death occurred at 4:50 p.m. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 12-26-60			
22c. PHYSICIAN'S NAME (Type) IRVIN M. COSSGROVE				22d. ADDRESS 301 ARNOLD ST. MONTGOMERY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Dec. 29/1960				23b. NAME OF CEMETERY OR CREMATORY Church of Assension Cem. Bowie, Md.			
23c. LOCATION (City, town, or county) (State)				23d. DATE BY REGISTRAR DEC 29 '60			
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED

14523

TO THE HONORABLE SECRETARY OF THE
NAVY
WASHINGTON, D. C.
DEAR SIR:
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above subject.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. M. [Signature]

CERTIFICATE OF DEATH

Reg. Dist. No.

14227

14313

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rysd - Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deane's Care Home		d. STREET ADDRESS 1102 St	
3. NAME OF DECEASED (Type or print) Florence M Grayson		4. DATE OF DEATH Dec 15 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1886 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alec Carter		14. MOTHER'S MAIDEN NAME Mary Frances Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Elnora Deane		Address Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mos undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1956 to Dec 1960 that I last saw the deceased alive on Dec 14, 1960, and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry A. Wise Jr. M.D.		DATE SIGNED July 12, 1960	
PHYSICIAN'S NAME (Type) Henry A. Wise, Jr.		149 9th St Bowie, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/60	22c. NAME OF CEMETERY OR CREMATORY Ascension Ch. Cath.	22d. LOCATION (City, town, or county) (State) Bowie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE DEC 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14228

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital					
3. NAME OF DECEASED (Type or print) Mery L GREEN			4. DATE OF DEATH Dec 11 1960		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1901	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Primus Bowen			14. MOTHER'S MAIDEN NAME Hanna Blunt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-42-1777		17. INFORMANT William Swindell (Son) Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Congestive Heart Failure DUE TO (b) Cardio Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/11/60	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
23. FUNERAL DIRECTOR Frager Funeral Home Inc		22d. LOCATION (City, town, or county) Suitland, Md		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
VS. A15ME 5M 7/59		DATE DEC 14 '60		C. H. H. H.	

14-00000

Grand Jury

2001 2002 2003

1901, 2001

Environ Biol Fish (2008) 81:239–247

James H. Jones

11

Page 100

Anda's Convictive Heart Failure

Charles Yarnall, Rural Doctor

Primo Rovera

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please include the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

1 ~~XP~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14245 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14229

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundle c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mayo d. STREET ADDRESS Box 278K, Edgewater	
3. NAME OF DECEASED (Type or print) ESTHER KATRINA GROVE		4. DATE OF DEATH Month December Day 4 Year 19 60.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Clerk		11. BIRTHPLACE (State or foreign country) Paris, Illinois	
13. FATHER'S NAME Thomas M. Black		14. MOTHER'S MAIDEN NAME Wilhelmima Oelschleiger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Virginia Schofield,		Address 1404 Vier Mills, Rd., Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 4 hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O. Watkins EXAMINER'S NAME (Type) DAYTON O. WATKINS, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 4, 1960.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-6-60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or country) (State) Bladensburg, Maryland.
23. FUNERAL DIRECTOR LEE FUNERAL HOME, 4th & Mass. Ave., N.E., Wash. DC		24a. REC'D BY REGISTRAR DEC 6 '60 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

12213

12213

Prince George County

Virginia

June 1900

County

101

101

Prince George County, Virginia

Box 222, Richmond

EXHIBIT

EXHIBIT

EXHIBIT

EXHIBIT

Female

Married - Clerk

At Home - US Govt Lodge, Illinois

Home - Black

Wilhelmina O'Connell

Home

Home

Mr. Virginia O'Connell, 101, Madison, Va.

101, Madison, Va.

MARY O. WALKER, M. D.

Fort Lincoln Cemetery

Richmond, Virginia

Richmond, 1900

THE GENERAL INDEX, 4th Edition, N. S. Walker, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14289

CERTIFICATE OF DEATH

Reg. Dist. No.

14230

1. PLACE OF DEATH o. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FAIRMOUNT Hgts</i>		c. LENGTH OF STAY IN 1b <i>30</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6112 Jost st</i>		d. STREET ADDRESS <i>6112 Jost st</i>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>HARVEY</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-22-1889</i>
9. AGE (In years lost birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Anna Green</i>		Address <i>6112 Jost st</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO <i>5 yrs.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Conditions age</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 18, 1960</i> , to <i>Dec. 31, 1960</i> , that I last saw the deceased alive on <i>Dec. 30, 1960</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Robinson</i>		ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. NE</i>	
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i>		DATE SIGNED <i>12-31-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-3-60</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Harmony Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Hydland Park Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nemy S. Washnuta</i>		ADDRESS <i>4925 Neane Ave</i>	
24a. REC'D BY REGISTRAR <i>AN 4 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

CERTIFICATE OF DEATH

14280

<p>1. NAME OF DECEASED <i>John William Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>65</i></p>	
<p>4. DATE OF DEATH <i>June 15, 1968</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Maryland</i></p>	
<p>10. OCCUPATION <i>Retired</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. PREVIOUS ILLNESS <i>None</i></p>		<p>14. MEDICAL HISTORY <i>None</i></p>		<p>15. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>16. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>17. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>18. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>20. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>21. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>22. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>23. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>24. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>26. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>27. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>28. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>29. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>30. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>32. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>33. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>34. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>35. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>36. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>38. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>39. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>40. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>41. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>42. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>44. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>45. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>46. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>47. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>48. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>50. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>51. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>52. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>53. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>54. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>56. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>57. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>58. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>59. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>60. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>62. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>63. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>64. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>65. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>66. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>68. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>69. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>70. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>71. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>72. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>74. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>75. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>76. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>77. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>78. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>80. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>81. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>82. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>83. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>84. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>86. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>87. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>88. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>89. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>90. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>92. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>93. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>94. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>95. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>96. SIGNATURE OF WITNESS <i>John William Smith</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>98. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>99. SIGNATURE OF DECEASED <i>John William Smith</i></p>	
<p>100. SIGNATURE OF WITNESS <i>John William Smith</i></p>		<p>101. SIGNATURE OF DECEASED <i>John William Smith</i></p>		<p>102. SIGNATURE OF WITNESS <i>John William Smith</i></p>	

CENTRAL OFFICE

1411

[The following text is extremely faint and largely illegible. It appears to be a series of lines of text, possibly a list or a set of instructions, spanning the majority of the page. Some words are difficult to discern but may include terms related to land management or surveying.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2159

1
FOR STATE
HEALTH DEPT.

14248 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14248

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14232

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta Hill		4. DATE OF DEATH Month December Day 25 Year 1960	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1960	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Roosevelt Hill		14. MOTHER'S MAIDEN NAME Kissca Scuelock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Roosevelt Hill, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 25, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-27-60 Nat. Harmony Mem Park, Highland Park, Md.		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Henry S Washington		ADDRESS 4925-Deane Ave NE	
24a. REC'D BY REGISTRAR DEC 28 '60		24b. REGISTRAR'S SIGNATURE Arthur P. ...	

1930
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

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Handwritten signature or initials

14247

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14233

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale 49	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 2022 Hayden Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Signa Middle Marie Last Hirnissey				4. DATE OF DEATH Month December Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-02	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.		IF UNDER 24 HRS. 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Denmark	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Chis Anderson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219 32 4082		17. INFORMANT Address Elwood A Hirnissey Avondale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 153.9 DUE TO Primary Carcinoma of The Colon. Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 11, 1960 to December 17, 1960 , that (I) (we) last saw the deceased alive on Dec. 17, 1960 and that death occurred at 3:50 PM from the causes and on the date stated above.							
22a. SIGNATURE Irvin M. Grassgreen M.D.				22b. DATE SIGNED DEC 17-1960			
22c. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN M.D.				22d. ADDRESS MT RAINIER, MD -			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 21, 1960		23c. NAME OF CEMETERY OR CREMATORY Columbia		23d. LOCATION (City, town, or county) (State) Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch' Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE DEC 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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CHIEF CLERK

VS. A15ME
5M 7/59

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14234

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patricia Ann		4. DATE OF DEATH Month Dec Day 14 Year 19 60	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 March 1947	
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR Months 13 Days 14 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grade School	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Franklin Hoffman		14. MOTHER'S MAIDEN NAME Lois Frances Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Richard N. Garner		Address same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression of Spinal Cord DUE TO (b) Fracture and dislocation of first and second cervical vertebrae DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Hiding on sleigh that collided with and parked auto		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9:36 AM 12-14 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Capital Hts., Prince Georges, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 14 Dec. 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec-17-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or country) (State) Southland Md	
23. FUNERAL DIRECTOR Simmons Bros		24a. REC'D BY REGISTRAR DEC 19 1960	
24b. REGISTRAR'S SIGNATURE William S. Jones			

may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14249

CERTIFICATE OF DEATH

14235

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN 1b 4 Hr. 20 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4506 Amherst Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Duncan Holmes		First Middle Last		4. DATE OF DEATH Dec. 10 1960		Day Month Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fletcher Holmes				14. MOTHER'S MAIDEN NAME Maud Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 9/1918- 12/1918 - - -		17. INFORMANT Rutson L. Holmes		Address 4506 Amherst Rd. College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 45 IX IMMEDIATE CAUSE (a) Cardiac Tamponade Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dissecting Aortic Aneurysm (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-9-1960 to 12-10-1960 that (I) (we) last saw the deceased alive on 12-10-1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. David Kerr, M.D. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-10-60	
22c. PHYSICIAN'S NAME (Type) Dr. David Kerr, M.D.				22d. ADDRESS 912 49th Ave. College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-1960		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery.		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudin ADDRESS 1756-14th Ave. NW Wash. D.C.				25a. REC'D BY REGISTRAR DATE DEC 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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OFFICE OF DEATH

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Highly rated as follows:

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Richard Franklin Root

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Page 2 of 2

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October 29, 1960

CERTIFICATE OF DEATH

Reg. Dist. No. 14237

14315

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariabona</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariabona</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFA #2, Box 2142</u>				d. STREET ADDRESS <u>RFA 2, Box 2142</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adeline</u> <u>Mercer</u> <u>Hunter</u>				4. DATE OF DEATH Month Day Year <u>Dec</u> <u>19</u> <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 29, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Mercer</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Briscoe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Helen Hunter Smith</u> <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerotic Vascular Disease.</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>19 Dec</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>17 Dec</u> , 19 <u>60</u> , and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.B. Sasser</u>				DATE SIGNED <u>29 Dec 60</u>			
PHYSICIAN'S NAME (Type) <u>R.B. Sasser</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-3-1961</u>		<u>Rock Creek Cemetery</u>		<u>Woburn St NW, Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>				ADDRESS <u>3072 M St NW</u>		24a. REC'D BY REGISTRAR <u>JAN 5 1961</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>James S. Thomas</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS MARRIAGES

PREVIOUS CHILDREN

PREVIOUS SIBLINGS

PREVIOUS PARENTS

PREVIOUS GRANDPARENTS

PREVIOUS GREAT-GRANDPARENTS

PREVIOUS AUNT/UNCLES

PREVIOUS COUSINS

PREVIOUS NEPHEWS/NIECES

PREVIOUS SISTER-IN-LAW

PREVIOUS BROTHER-IN-LAW

PREVIOUS SONS/DAUGHTERS

PREVIOUS GRANDCHILDREN

PREVIOUS GREAT-GRANDCHILDREN

PREVIOUS AUNT/UNCLES

PREVIOUS COUSINS

PREVIOUS NEPHEWS/NIECES

PREVIOUS SISTER-IN-LAW

PREVIOUS BROTHER-IN-LAW

PREVIOUS SONS/DAUGHTERS

PREVIOUS GRANDCHILDREN

PREVIOUS GREAT-GRANDCHILDREN

PREVIOUS AUNT/UNCLES

PREVIOUS COUSINS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14250

CERTIFICATE OF DEATH

14238

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5400 20th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Effie M. Hunter				4. DATE OF DEATH Month Day Year December 17 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-82	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Williams				14. MOTHER'S MAIDEN NAME Lucinda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-03-4642		17. INFORMANT Mary K. Cot. Daughter Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aplastic anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) known to chest						INTERVAL BETWEEN ONSET AND DEATH 12-10-60	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-14 19 60 , to 12-17 19 60 , that (I) (we) last saw the deceased alive on 12-17 19 60 , and that death occurred at 6:15 PM from the causes and on the date stated above.							
22a. SIGNATURE George Hageage				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-19-60	
22c. PHYSICIAN'S NAME (Type) George Hageage, Md D.				22d. ADDRESS Mt. Rainier., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/21/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE DEC 27 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

1 14251 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14239

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret (Maggie) Nellie Huston</u>				4. DATE OF DEATH Month Day Year <u>Dec 1, 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29, 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Neal Fry</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Andrew Huston, Husband, Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PONTINE HEMMORRHAGE</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBAL THROMBOSIS, MASSIVE, LEFT</u> DUE TO (c) <u>CEREBAL ARTERIO SCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>1 WEEK</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 28, 1960</u> , to <u>Dec 1, 1960</u> , that I last saw the deceased alive on <u>Nov 30, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6124 41st Ave, Hyattsville, Md</u> DATE SIGNED <u>12/2/60</u>							
ACTUAL SIGNATURE <u>Gordon W Kelley</u> M.D.				PHYSICIAN'S NAME (Type) <u>Gordon Kelly</u> <u>6124 41st Ave, Hyattsville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec 5, 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. National</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St SE Wash, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14521

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14240

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bank of Kothalworth Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY None c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4702 Jay Street N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN FRANCIS JACKSON			4. DATE OF DEATH Month December Day 28 Year 1960				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1882		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Capital Traction		11. BIRTHPLACE (State or foreign country) Charles County, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown				
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 578-10-8335			17. INFORMANT 2721 Adams Mill Rd N.W. Mary F. Turner- Sister in law				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXPOSURE TO COLD 932.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 28, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
22d. LOCATION (City, town, or country) (State) Washington, D.C.		23. FUNERAL DIRECTOR John S. Stewart ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR JAN 3 '61 DATE			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No. 14241

14316

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> 58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7008-22 Avenue</u>		d. STREET ADDRESS <u>7008 22nd AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Grace Noel Johnson</u>		4. DATE OF DEATH <u>December 8 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 Oct 1890</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Robert Lantz</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hammon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Eliz. F. Sheetz</u>		Address <u>734 Van Buren N.W. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest and cachexia</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized carcinomatosis</u> DUE TO <u>171X</u> (c) <u>Carcinoma cervix and large intestine</u> 5 yrs.			INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathological fracture right hip with non union</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1930</u> to <u>Dec 8</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7 Dec</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas P. Mattingly M.D.</u>		ADDRESS (Street, city or town, state) <u>2206 Rhode Is. Ave N.E.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas P. Mattingly M.D.</u>		Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woods</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW</u>	24c. RECEIVED BY REGISTRAR DATE <u>DEC 12 60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-11-18

[Faint, mostly illegible text follows, likely containing personal details and medical history.]

14293
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 14242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 617 8th Street..				d. STREET ADDRESS 617 8th Street..			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle EMMA Last JOHNSON		4. DATE OF DEATH Month Dec. Day 14, Year 19 60					
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1873	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Watkins				14. MOTHER'S MAIDEN NAME Sallie Colbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Elva Wesley: 617 8th St., Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420J DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary Sclerosis Gen'l. Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Gen'l. Arteritis				INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 15 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/3/37 to 12/13/60 that (I) (we) last saw the deceased alive on 12/13/60 and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE J. M. WARREN				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) J. M. WARREN				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/60		23c. NAME OF CEMETERY OR CREMATORY Mirkirk.,		23d. LOCATION (City, town, or county) (State) Mirkirk, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				25a. REC'D BY REGISTRAR DATE DEC 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

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CERTIFICATE OF DEATH

1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14317
14243
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 50 M. St., S. E.	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Johnson		4. DATE OF DEATH Month 12 Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dickson Johnson		14. MOTHER'S MAIDEN NAME Molly ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown?	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with acute heart failure DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe secondary anemia, chronic renal disease, probably pyelonephritis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/26/1960 to 12/16/1960, that (I) (we) last saw the deceased alive on 12/16/1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/16/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL / CREMATION, REMOVAL (Specify) 12/23/60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Washington DC	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR DATE DEC 28 '60	
442 M St. N.W.		25b. REGISTRAR'S SIGNATURE	

CENTRAL AIR OF DEATH

1. The first of the three main types of death is the natural death. This is the death which occurs as a result of the normal processes of aging and disease. It is the most common type of death and is usually preceded by a long period of illness or infirmity. The second type of death is the accidental death. This is the death which occurs as a result of an accident, such as a fall, a fire, or a car crash. The third type of death is the suicide. This is the death which occurs as a result of a person's own hand. It is the least common type of death and is usually preceded by a long period of mental distress.

2. The first of the three main types of death is the natural death. This is the death which occurs as a result of the normal processes of aging and disease. It is the most common type of death and is usually preceded by a long period of illness or infirmity. The second type of death is the accidental death. This is the death which occurs as a result of an accident, such as a fall, a fire, or a car crash. The third type of death is the suicide. This is the death which occurs as a result of a person's own hand. It is the least common type of death and is usually preceded by a long period of mental distress.

3. The first of the three main types of death is the natural death. This is the death which occurs as a result of the normal processes of aging and disease. It is the most common type of death and is usually preceded by a long period of illness or infirmity. The second type of death is the accidental death. This is the death which occurs as a result of an accident, such as a fall, a fire, or a car crash. The third type of death is the suicide. This is the death which occurs as a result of a person's own hand. It is the least common type of death and is usually preceded by a long period of mental distress.

4. The first of the three main types of death is the natural death. This is the death which occurs as a result of the normal processes of aging and disease. It is the most common type of death and is usually preceded by a long period of illness or infirmity. The second type of death is the accidental death. This is the death which occurs as a result of an accident, such as a fall, a fire, or a car crash. The third type of death is the suicide. This is the death which occurs as a result of a person's own hand. It is the least common type of death and is usually preceded by a long period of mental distress.

5. The first of the three main types of death is the natural death. This is the death which occurs as a result of the normal processes of aging and disease. It is the most common type of death and is usually preceded by a long period of illness or infirmity. The second type of death is the accidental death. This is the death which occurs as a result of an accident, such as a fall, a fire, or a car crash. The third type of death is the suicide. This is the death which occurs as a result of a person's own hand. It is the least common type of death and is usually preceded by a long period of mental distress.

CERTIFICATE OF DEATH

Reg. Dist. No. 14244

14318

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill 14			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5881 Rosecroft Drive				d. STREET ADDRESS 5881 Rosecroft Drive 1			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Edward Jones				4. DATE OF DEATH Month Day Year Dec. 19, 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 9, 1885	
				9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Scott Jones				14. MOTHER'S MAIDEN NAME Lilly Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> no <input type="checkbox"/> (If yes, give year or dates of service) WWI				16. SOCIAL SECURITY NO. no			
17. INFORMANT Alice Elizabeth Jones Lewis-Drive- Oxon Hill, Md.				Address 5881 Rosecroft Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic Carcinoma of lung, 1 year</u> 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 3</u> , 19 <u>60</u> , to <u>Dec 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>60</u> , and that death occurred at <u>10 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John P. DiAngelo M.D. 4223 Silver Hill Rd. Wash DC (Silver Hill) Md.							
ACTUAL SIGNATURE John P. DiAngelo							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/19/60		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) (State) Charlottesville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. -2901 14th St. N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE DEC 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14252

CERTIFICATE OF DEATH

14245

1. PLACE OF DEATH a. COUNTY <i>Pr. George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr. George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brown</i>				c. LENGTH OF STAY IN 1b <i>1/2 hr</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dr. Langer, Earl Hay</i>				d. STREET ADDRESS <i>1 Shucklerville Rd</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Bessie</i> Middle <i>M</i> Last <i>Kreitzer</i>				4. DATE OF DEATH Month <i>Dec</i> Day <i>1</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 12, 1894</i>	
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Clarence R Painter</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Patterson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT Address <i>Mr William C Kreitzer Sr Bowie, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral haemorrhage</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>January 1945</i> to <i>Dec 1, 1960</i> , that (I) (we) last saw the deceased alive on <i>Dec 1, 1960</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert S. McCeney</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Robert S. McCeney, M.D.</i>	
22d. ADDRESS <i>402 Main Street, Laurel, Md.</i>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 6, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Lutheran Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Bowie, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis Paschi, Jr., Hyattsville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 5 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

BP

CERTIFICATE OF DEATH

12225

Witnessed & attested

Dr. William C. Bennett, M.D.

Witnessed & attested

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14219

CERTIFICATE OF DEATH

Reg. Dist. No.

14240

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 13003 PARKLAND DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle C. Last LAAKE		4. DATE OF DEATH Month 12- Day 25- Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-70
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 90	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE BELINGER		14. MOTHER'S MAIDEN NAME HANNA BRADLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT SACRED HEART HOME RECORDS* SAME AS #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-18-59 , 19 59 , to 12-25 , 19 60 , that I last saw the deceased alive on 12-23-60 , 19 60 , and that death occurred at 10:40 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 322 - H NE DATE SIGNED ACTUAL SIGNATURE Thomas F Collins M.D. PHYSICIAN'S NAME (Type) THOMAS F COLLINS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-28-60	22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins FRANCIS J. COLLINS		24a. REC'D BY REGISTRAR DEC 27 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE ATTORNEY GENERAL

1910

IN RE

STATE OF TEXAS

VS

JOHN W. BROWN

DEBTOR

IN BANKRUPTCY

FILE NO.

10000

FILED IN THE DISTRICT COURT OF THE

SOUTHERN DISTRICT OF TEXAS

AT SAN ANTONIO, TEXAS

THIS 10TH DAY OF JANUARY

1910

CLERK OF DISTRICT COURT

JOHN W. BROWN

DEBTOR

IN BANKRUPTCY

FILE NO. 10000

FILED IN THE DISTRICT COURT OF THE

SOUTHERN DISTRICT OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14247

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write Hillcrest Heights)		c. CITY OR TOWN (If outside corporate limits, write Hillcrest Heights)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5013 26th Ave.		d. STREET ADDRESS 5013 26th Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First S herman Middle L Last Lager		4. DATE OF DEATH Month Dec Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1913
9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 18 Days 1	
11. IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Government		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur L. Lager		14. MOTHER'S MAIDEN NAME Alice Frosberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 284-03-7290	
17. INFORMANT Marian J. Lager,		Address same as ld Wife	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Carcinoma of colon DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Jan 60 to 20 Dec 60 that (I) (we) last saw the deceased alive on 12-20-60 and that death occurred at 3:30 AM from the causes and on the date stated above.			
22a. SIGNATURE John P. Royce		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4223 Silver Hill Rd - Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/60	
23c. NAME OF CEMETERY OR CREMATORY Lakeview		23d. LOCATION (City, town, or county) (State) Jamestown, N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Wash. D.C.		25a. REC'D BY REGISTRAR DATE DEC 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1-11-19

George Washington

11-11-19

11-11-19

George Washington

11-11-19

George Washington

11-11-19

11-11-19

CHIEF OF BUREAU

MAILED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14248										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Fredrick					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fredrick			d. STREET ADDRESS Box 366 Rt. # 5		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Linda Robin LEOPOLD					4. DATE OF DEATH Dec 24 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Aug 1943		9. AGE (In years last birthday) 17 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Sidney Leopold					14. MOTHER'S MAIDEN NAME Harriet Simon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. ***		17. INFORMANT Sidney Leopold			Address same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Crushing injuries to head and body, Multable and severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Occupant of car that ran off road								INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of car that ran off road							
20c. TIME OF INJURY 12:30 a.m. 12/24 1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parkway		20f. (City or town) (County) (State) Kensington Prince George's Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd			DATE SIGNED 12/24/1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12-27-60		22c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		22d. LOCATION (City, town, or country) (State) Elmont, L.I., New York			
23. FUNERAL DIRECTOR Bernard Danzansky & Sons					ADDRESS 3501 14th Street, NW		24a. REC'D BY REGISTRAR DEC 27 '60			
							24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Prince George General Hospital

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County of _____

City of _____

State of _____

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Rogers Heights d. STREET ADDRESS 5410 Emerson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) Grace Kirby Little				4. DATE OF DEATH December 25 19 60				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 26, 1911 49 yrs.				9. AGE (In years last birthday) 49				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				11. BIRTHPLACE (State or foreign country) Tennessee				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles L Kirby								14. MOTHER'S MAIDEN NAME Malinda C Huffaker								15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. 38I-IO-2626				17. INFORMANT Guy T. Little, same as # 32 2								18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart Failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12/25/60 DATE SIGNED James I. Boyd M.D. EXAMINER'S NAME (Type) James I. Boyd 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/29/60 22c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery 22d. LOCATION (City, town, or country) (State) Maryville, Tennessee 23. FUNERAL DIRECTOR W. W. CHAMBERS CO., ADDRESS Riverdale, Maryland. 24a. REC'D BY REGISTRAR DEC 29 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Place of death: _____

Physician: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

Place of death: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14256

14251

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3518 Buchanan St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Leona Last Lizear		4. DATE OF DEATH Month Dec. Day 31 Year 60	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1895 9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 13. FATHER'S NAME Lee Johnson		10b. KIND OF BUSINESS OR INDUSTRY self 14. MOTHER'S MAIDEN NAME Margaret Cox	
11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? U S A		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Nettie Taylor Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO 15 yrs (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 4 days 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-27- 1960 to Dec. 31 , 19 60 , that (I) (we) last saw the deceased alive on 12-30 , 19 60 , and that death occurred at 4A M, from the causes and on the date stated above.			
22a. SIGNATURE John P. Clum 22c. PHYSICIAN'S NAME (Type) Dr. John P. Clum M.D.		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6110 43rd Ave. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		23d. LOCATION (City, town, or county) (State) Beltsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 5 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14252

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Illinois b. COUNTY Lake c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lake Forest d. STREET ADDRESS 881 Oakwood e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH J. LOUIS				4. DATE OF DEATH Month December Day 25 Year 1960.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1898	
9. AGE (in years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Joliet, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address 6934 Decatur St., Woodlawn, Hyatts., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 26, 1960.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1960		22c. NAME OF CEMETERY OR CREMATORY Ridgewood Cemetery		22d. LOCATION (City, town, or country) (State) Des Plaines, Illinois	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., ADDRESS Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE DEC 29 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

1:257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

John

Illinois

Prince Georges County

John Jones

IDA

Germany

201 Greenwood

Prince Georges General Hospital

JOHN

J.

JOHN

Male

White

Sept. 19, 1928

62

Illinois U.S.A.

John

Steel

Infantry

John

Infantry

622, Lexington St.,

Woodlawn, Baltimore, Md.

yes, when Mrs. Grace E. Jones

Home

Coronary Occlusion

Cardiovascular renal disease

X X

X

X

X

December 21, 1960.

JAMES I. JONES, M.D.

The Tribune, Illinois

The Tribune, Maryland

Dec. 21, 1960

W. H. THOMPSON CO.,

Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
14258 CERTIFICATE OF DEATH 14253											
1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY						c. LENGTH OF STAY IN 1b 1527-2					
d. NAME OF HOSPITAL (If in institution, write name of institution) 2601 CHEVERLY AVE. ADSACORDIA NURSING HOME						d. STREET ADDRESS 2612 EAST WEST HIGHWAY					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First MARY Middle MACKIE Last MACKIE						4. DATE OF DEATH Month 12 Day 15 Year 1960					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1883		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CHRISMORE						14. MOTHER'S MAIDEN NAME Cora Boyden					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 577-20-6097		17. INFORMANT Mrs. Clara Thompson				Address Hyattsville, Md. 1800 Crosby Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) Cerebral Vascular Thrombosis DUE TO (c) Arteriosclerotic Aneurysm of Aorta										INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Aneurysm of Aorta											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 1955 to Dec 15, 1960		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1955 to Dec 15, 1960 , that (I) (we) last saw the deceased alive on Dec 14, 1960 , and that death occurred at 8:00 AM , from the causes and on the date stated above.											
22a. SIGNATURE W. Robert Perkins						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/15/1960			
22c. PHYSICIAN'S NAME (Type) W. Robert Perkins						22d. ADDRESS 1463 - Rhode Island Ave NW.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 12/19/60		23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City, town, or county) (State) Martinsburg, West Va.			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.						ADDRESS 2901 14th St. N.W. Washington 9, D.C.		25a. REC'D BY REGISTRAR DEC 19 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

THE UNIVERSITY OF CHICAGO PRESS

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

10

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1000

14220

47X-3

5. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

VR A15 (4)
ISM 9/59

14253

Director, Bureau of Census

Washington, D. C.

Enclosure

Very truly yours,

AMERICAN AIRLINES
CENTRAL OFFICE
WASHINGTON, D. C.

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]
SUBJECT: [illegible]

RE: [illegible]
DATE: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]

Very truly yours,
[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14257

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN lb 2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5312 BRANCH AVENUE, S.E.		d. STREET ADDRESS 3040 Idaho Avenue, N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATHARINE Middle BROWN Last MAYNARD		4. DATE OF DEATH Month DEC. Day 27 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1898
9. AGE (In years lost birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Director		10b. KIND OF BUSINESS OR INDUSTRY Personnel, Dept. Int.	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. L. BROWN		14. MOTHER'S MAIDEN NAME Clara SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Clarence C. Gill, 10,620 Edgewood Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) Arterio sclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. 6 mos. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1 , 19 60 , to Dec. 27 , 19 60 , that I last saw the deceased alive on Dec. 9 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4600 Conn. Ave., N.W. DATE SIGNED 12/27/60			
ACTUAL SIGNATURE <i>Richard Spire</i>		M.D. 4600 Conn. Ave., N.W.	
PHYSICIAN'S NAME (Type) RICHARD SPIRE		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/30/60	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i>		24a. REC'D BY REGISTRAR DATE JAN 3 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kram</i>			

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CERTIFICATE OF DEATH

Reg. Dist. No. 14258

14322

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland Park, St. Pet.</i>		c. LENGTH OF STAY IN 1b <i>9 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ROBERT</i> First <i>PATTERSON</i> Middle <i>MCLEWAIN</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>28</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-1890</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT MARY ARMSTRONG</i> Address <i>5419 WALLS ST. SUITLAND, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEART ARREST</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>HYPERTENSION</i> DUE TO (c) <i>SEVERAL YEARS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>ABOUT JAN. 1954</i> , to <i>12-15</i> , 1960, that I last saw the deceased alive on <i>12-15</i> , 1960, and that death occurred at <i>0:20 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Miguel A. Huici</i>		DATE SIGNED <i>5234 LIVINGSTON RD. 12-28-60</i>	
PHYSICIAN'S NAME (Type) <i>MIGUEL A. HUICI</i>		<i>OXON HILL, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-30-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington Natl</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sevinced Bros.</i> ADDRESS <i>1661- 2nd Hope Rd SE WASH DC</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

14330
M. J. O'NEILL



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14259

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forrestville d. STREET ADDRESS 5606 Richie Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Eva Viola McKENNEY		4. DATE OF DEATH Month Dec. Day 23 Year 19 60		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 May 1893		9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 23 Hours 19 Min. 60									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Leslie Burmette							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 2X DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular Renal Disease DUE TO (c) Cardiovascular Renal Disease				INTERVAL BETWEEN ONSET AND DEATH				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/23/60							
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/27/60				22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem				22d. LOCATION (City, town, or county) (State) Suitland Rockledge Co Md.			
23. FUNERAL DIRECTOR W.W. Chambers Co.				ADDRESS 517-1195156				24a. REC'D BY REGISTRAR DATE DEC 29 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

MEDICAL CERTIFICATION

13260

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14261											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1229 Ram Street N. E. d. STREET ADDRESS 1229 Ram Street N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Willie Harrison McRae First Middle Last						4. DATE OF DEATH December 31 1960 Month Day Year					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1905		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper				10b. KIND OF BUSINESS OR INDUSTRY Kitchen				11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harrison McRae				14. MOTHER'S MAIDEN NAME Katy Brown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Thelma McRae, same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMOPERICARDIUM and CARDIAC TAMPONADE 982 DUE TO (b) Knife wound of HEART Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during an Altercation							
20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 12/31 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) North Brentwood P. G. Md		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				M.D. James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/31/60		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-61		22c. NAME OF CEMETERY OR CREMATORY New Zion Church				22d. LOCATION (City, town, or country) (State) Clio, South Carolina.			
23. FUNERAL DIRECTOR Frazier's Funeral Home Inc, 389 R.I.Ave, D.C.						ADDRESS		24a. REC'D BY REGISTRAR JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

FOR SALE
EASTMAN

Prince George's

Barbary

Prince George's

William

Life Colored

Holder

Harrison Moore

1

Director of Columbia

Washington

1901

1901 from George H. H.

Moore

Harrison

July 4, 1901

South Carolina

Kitchen

Life Brown

Thomas Moore, name no 42

Shopped during an altercation

2:30

12/21/00

12/21/00

North Carolina

James I. Moore

12/21/00

12/21/00

12/21/00

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3hr 50 m			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Miller				4. DATE OF DEATH Month Dec. Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Dec. 1960	
9. AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 50		IF UNDER 24 HRS. Hours 3 Min. 50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stanley Miller				14. MOTHER'S MAIDEN NAME Florence DODA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Stanley L. Miller		Address same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity DUE TO 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) premature labor DUE TO 6 1/2 hrs. (c) premature rupture of membranes DUE TO 4 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12-24-60 INTERVAL BETWEEN ONSET AND DEATH 3 28 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec. 23, 1960 , to Dec. 24, 1960 that (I) (we) last saw the deceased alive on Dec. 24, 1960 , and that death occurred at 1:50 AM from the causes and on the date stated above.							
22a. SIGNATURE R. Kennedy Skyston M.D.				22b. DATE SIGNED 12-24-60			
22c. PHYSICIAN'S NAME (Type) R. KENNEDY SKYSTON				22d. ADDRESS PRINCE GEORGES GEN HOSPITAL, CHEVERLY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec 28, 60		23c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE MEM.		23d. LOCATION (City, town, or county) (State) ELKRIDGE - MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale Md.				25a. REC'D BY REGISTRAR DEC 29 '60		25b. REGISTRAR'S SIGNATURE Christina S. Kline	

1882

DEATH OF DEATH

1882

1

CERTIFICATE OF DEATH

Reg. Dist. No.

14263

15323

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADELPHI				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADELPHI			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9015 ADELPHI RD				d. STREET ADDRESS 9015 ADELPHI RD.			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MARGARET MILLS				4. DATE OF DEATH Month Day Year DEC 6, 1960			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME VALENTINE WIELAND				14. MOTHER'S MAIDEN NAME CATHERINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS MILDRED SCHULZE DAUGHTER SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INSUFFICIENCY 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROSIS-GENERALIZED (c) 8 YRS INTERVAL BETWEEN ONSET AND DEATH 4 MOS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY 7 , 19 57 , to 12/6 , 19 60 , that I last saw the deceased alive on 11/15 , 19 60 , and that death occurred at 7:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold Sterling M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 13524 UNIVERSITY BLVD. HYATTSVILLE, MD			
PHYSICIAN'S NAME (Type) HAROLD STERLING MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-9-60		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) BLADENSBURG, MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14324

14264

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		d. STREET ADDRESS 6707 BRINKLEY RD WASH 22 DC	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle (NMI) Last MISKINIS		4. DATE OF DEATH Month DECEMBER Day 18 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 SEPTEMBER 1890
9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM STRICKAITES		14. MOTHER'S MAIDEN NAME MAGDALENE GRENAVAGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CAPTIAN E. MISKINIS		Address 6707 BRINKLEY RD WASH 22 DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA, LYMPHATIC, CHRONIC DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 204.10 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE AHA III-D TUBERCULOSIS, PULMONARY		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 DEC 1960 to 18 DEC 1960 , that (I) (we) lost saw the deceased alive on 17 DEC 1960 , and that death occurred at 3:30 A. M., from the causes and on the date stated above.			
22a. SIGNATURE Edwin E. Westura		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EDWIN E. WESTURA, CAPT USAF MC		22d. ADDRESS USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20 1960	
23c. NAME OF CEMETERY OR CREMATORY St. Casimiro Cemetery		23d. LOCATION (City, town, or county) (State) St. Clair, Pa. (Port Arden)	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc		ADDRESS 816 H St NE.	
25a. REC'D BY REGISTRAR DATE DEC 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

Blank certificate form with two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14221

Item 2 Film 0278 1-10-61 et

CERTIFICATE OF DEATH

14265

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR 4922 LANSALLE RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederic S. Moise		4. DATE OF DEATH December 13 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		11. BIRTHPLACE (State or foreign country) NEW ORLEANS, LA	
13. FATHER'S NAME DAVID CALHOUN MOISE		14. MOTHER'S MAIDEN NAME CORA A. WASHINGTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sister Agnes Patricia		Address 4922 Lansalle Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intussusception, Perforated 3322 * DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation DUE TO (c) Small intestine		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebral thrombosis R. Hemisphere		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/13/60 to 12/13/60 , that (I) (we) lost the deceased alive on 12/13/60 and that death occurred on 12/13/60 from the causes and on the date stated above.			
22a. SIGNATURE Chas H Wolheim MD		22b. DATE SIGNED 12/13/60	
22c. PHYSICIAN'S NAME (Type) Chas H Wolheim		22d. ADDRESS 7600 Carroll Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION (City, town, or county) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. RECEIVED BY REGISTRAR DEC 20 1960	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE William S. Thomas	

15531

CENTRAL AIR OF GREAT



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in accordance with 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14263

14266

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham 36	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 9219 Fowler Lane 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle A Last MOORE				4. DATE OF DEATH Month Dec Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 15, 1878	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME Charles Keleher				14. MOTHER'S MAIDEN NAME Katherine Heiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Clara L. Gundling Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardio Vascular Disease 4 yrs DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19 19 57 to Dec 28 19 60 , that (I) (we) last saw the deceased alive on OCT 13 19 60 , and that death occurred at 3 AM , from the causes and on the date stated above.							
22a. SIGNATURE Norman Donat Comeau M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/60	
22c. PHYSICIAN'S NAME (Type) Norman Donat Comeau				22d. ADDRESS 3503 Perry St Mt Rainier Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

14581

IN SENATE,
January 1, 1903.
REPORT
OF THE
ATTORNEY GENERAL,
JAMES C. CLARK,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 1, 1902,
RELATIVE TO THE
PROSECUTION OF
THE CASE OF
THE STATE OF NEW YORK
V. THE NEW YORK
CENTRAL AND
HARTFORD RAILROAD
COMPANY.
ALBANY: JAMES B. CLARK,
PRINTED BY THE
UNIVERSITY OF THE
STATE OF NEW YORK,
1903.

CERTIFICATE OF DEATH

Reg. Dist. No.

14267

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN lb 73 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP, ANDREWS AFB, WASH 25, DC				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON d. STREET ADDRESS ROUTE 2, BOX 71X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE K MORRIS				4. DATE OF DEATH Month Day Year DECEMBER 27 19 60			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 FEBRUARY 1886	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? DISTRICT OF COLUMBIA UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY RETIRED CIVIL SERVICE		11. BIRTHPLACE (State or foreign country) DISTRICT OF COLUMBIA UNITED STATES	
13. FATHER'S NAME CHARLES H KREY				14. MOTHER'S MAIDEN NAME ANNIE COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Capt. Stephen J. Morris		Address Clinton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Adenocarcinoma of Colon Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. } DUE TO (b) 24 months (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 14, 19 60 to Dec 27, 19 60 that I last saw the deceased alive on 27 Dec 19 60 and that death occurred at 1045 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles S. Moon M.D. USAF HOSPITAL ANDREWS 27 Dec 60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) CHARLES S MOON, CAPT USAF (MC) USAF HOSP, ANDREWS AFB, WASH 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros Wash D.C.				24a. REC'D BY REGISTRAR DATE DEC 29 '60		24b. REGISTRAR'S SIGNATURE Charles S. Moon	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be released by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
14264

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14268

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bladensburg	
c. LENGTH OF STAY IN 1b 9 days		d. STREET ADDRESS 4901 Taylor Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amos Otto Morrison		4. DATE OF DEATH Dec. 19 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1st Feb 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co	
11. BIRTHPLACE (State or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James W Morrison		14. MOTHER'S MAIDEN NAME Sarah A Fugitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Julia L Morrison		Address Bladensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal Ulcer DUE TO (c) Cerebral Thrombosis (right fronto,parietal)		INTERVAL BETWEEN ONSET AND DEATH 24 hours unknown 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-1 19 60 to 12-19 19 60 , that (I) (we) last saw the deceased alive on 12-19 19 60 and that death occurred on 5:50 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. A. Deitz, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1960	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Beijing, 12.12.1950. General Secretary

Dear Comrade Stalin:

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14326

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14269

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 4 months and 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1308 Girard St., N. W.			
3. NAME OF DECEASED (Type or print) First Annie Middle - Last Myles				4. DATE OF DEATH Month 12 Day 8 Year 19 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1887	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom Donaldson				14. MOTHER'S MAIDEN NAME Elizabeth Donaldson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix, grade IV, with regional metastases 171X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/15/60 to 12/8/60 1960, that (I) (we) last saw the deceased alive on 12/8/60 1960, and that death occurred at 4:10 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/8/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/60		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John L. Stewart				25a. REC'D BY REGISTRAR 20-H-16-NE		25b. REGISTRAR'S SIGNATURE DATE 12 60	

1

14294

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14270

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>106 7th Street</u>				d. STREET ADDRESS <u>106 7th St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>M.</u> Last <u>NICHOLS</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years lost birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Ashkin</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>C. Ernest Nichols Jr. Lanham Md</u> Address <u>106 7th St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Influenza</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1957</u> to <u>Dec 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 16, 1960</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank L. Weaver Jr</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER JR</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lanham, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>He Witt Danaldson</u>				25a. RECEIVED BY REGISTRAR <u>Arthur L. Frank</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

1951

[The body of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or memorandum.]

14327

CERTIFICATE OF DEATH

Reg. Dist. No.

14271

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Accokeek		c. LENGTH OF STAY IN 1b 1½ years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Accokeek			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1 Box # 116		d. STREET ADDRESS Route # 1 Box # 116	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle ROBERT Last O'BRIEN		4. DATE OF DEATH Month DECEMBER Day 26th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18th, 1906
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk--Retired		10b. KIND OF BUSINESS OR INDUSTRY Auto Parts	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas O'Brien		14. MOTHER'S MAIDEN NAME Lucia Gottsman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-03-5577	
17. INFORMANT Effie O'Brien, Route #1 Box #116, Accokeek, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis, general 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of aorta DUE TO (c) Arteriosclerotic cardiac disease		INTERVAL BETWEEN ONSET AND DEATH Since 1956 Since 1956 Since 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1956 , to Dec. 26, 1960 , that I last saw the deceased alive on Dec. 26, 1960 , and that death occurred on 11:50AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Chen		ADDRESS (Street, city or town, state) Accokeek, Md.	
PHYSICIAN'S NAME (Type) Paul Chen, M. D.		DATE SIGNED 12/26/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. SE, Wash. DC		24a. REC'D BY REGISTRAR DATE DEC 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14328
CERTIFICATE OF DEATH

14272

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>02 Rural Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Band Mill Road</i>		d. STREET ADDRESS <i>1 Band Mill Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i> First <i>Ossman</i> Middle Last		4. DATE OF DEATH Month <i>12</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 12, 1881</i> yrs. <i>79</i>
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Easton Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frederick Ossman</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Saker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>522x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac failure</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>3hr.</i> <i>3yr.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1959, to <i>Dec</i> 1960, that (I) (we) lost saw the deceased alive on <i>Dec 23, 1960</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank L. Weaver Jr.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>12/24/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>FRANK L. WEAVER, JR.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/26/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Highland Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witt Donaldson</i> ADDRESS <i>Laurel, Md</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 30 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

UNITED STATES OF AMERICA

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 12. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14274

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville d. STREET ADDRESS Pt. 2., Box 39 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Grafton Eldridge OWENS		4. DATE OF DEATH Month Dec Day 17 Year 1960		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 April 1921		9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 17		IF UNDER 24 HRS. Hours 17 Min. 1960			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Thomas Owens				14. MOTHER'S MAIDEN NAME Henrietta Turner				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-14-7471				17. INFORMANT Henrietta Owens (Mother) Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insuficiency DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Arterial Heart Disease (c) Coronary Arterial Heart Disease (a), stating the underlying cause last.																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.															
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19															
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) James I Boyd				DATE SIGNED 12/17/1960				Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-22-60				22c. NAME OF CEMETERY OR CREMATORY Galilee				22d. LOCATION (city, town, or country) (State) Galilee, Md.							
23. FUNERAL DIRECTOR William Reese #				ADDRESS Anna, Md.				24a. RECD BY REGISTRAR DEC 20 1960				24b. REGISTRAR'S SIGNATURE Arthur A. Thomas							

MEDICAL CERTIFICATION

1945

Prison
County

James George (James) [unclear]

11. 2. 39

Wife
Name
Date
1941

Inspector
Construction
U.S.A.

John James [unclear]
Henderson [unclear]

27-14-7471 Henderson [unclear] (Mother) Date of 2

Coroner's Inquest

Coroner's Medical Report [unclear]

1941/1942

James E. [unclear]

12-22-44
[unclear]
[unclear]

T4330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FORESTVILLE NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>W.</u> Middle <u>PAYNE</u> Last				4. DATE OF DEATH <u>DEC. 14</u> Month <u>14</u> Day <u>1960</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 28, 1876</u>	9. AGE (In years lost birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>TALBERT</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>			16. SOCIAL SECURITY NO. <u>?</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO INTESTINAL TRACT HEMORRHAGE</u> 578X DUE TO <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 days</u> (c) <u>10 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FAR ADVANCED RHEUMATOID ARTHRITIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year <u>NONE</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that I attended the deceased from <u>AUG. 15, 1960</u> to <u>PRESENT</u> , that I last saw the deceased alive on <u>Dec. 14, 1960</u> , and that death occurred at <u>940 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u>				ADDRESS (Street, city or town, state) <u>Branch Ave. Clinton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>				DATE SIGNED <u>12/14/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec 16-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sennons Bros</u>				ADDRESS <u>1661-9000 Ave rd SE</u>		24a. REC'D BY REGISTRAR <u>DEC 19 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1940

CERTIFICATE OF DEATH

PRINCE GEORGES HOSPITAL

POSTMORTEM

THE FOLLOWING NURSING HOME

LEVA W. PRINCE

DECEASED

POSTMORTEM

THE FOLLOWING

POSTMORTEM

THE FOLLOWING

THE FOLLOWING

THE FOLLOWING

THE FOLLOWING

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14331

CERTIFICATE OF DEATH

Reg. Dist. No. 14276

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Southern Md. Hosp. Center		d. STREET ADDRESS Rt. 3 Box 190	
3. NAME OF DECEASED (Type or print) Charles Theo. Peed		4. DATE OF DEATH December 9, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/97
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY FARM. (Own)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Amos Peed		14. MOTHER'S MARDEN NAME Barbara Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Pearl A. Peed Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 days undetermined			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1960, to Dec 9, 1960 that I last saw the deceased alive on Dec 9, 1960, and that death occurred at 10:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 12/9/60	
ACTUAL SIGNATURE Alfred Lapin by Ritchie Bros. Clinton MD			
PHYSICIAN'S NAME (Type) Alfred Lapin, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/60	
22c. NAME OF CEMETERY OR CREMATORY XXXX Immanuel Cem.		22d. LOCATION (City, town, or county) (State) Horsehead, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE DEC 20 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Film 276 12-19-60 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CORRECTED COPY											
14277											
CORRECTED COPY											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN lb 24 DAYS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP., ANDREWS AFB, WASH 25 D C				d. STREET ADDRESS 2772 FT SCOTT DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THEODORE				First PETERSON				4. DATE OF DEATH Month DECEMBER Day 6 Year 19 60			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 SEPTEMBER 1892		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIGAR MANUFACTURER				10b. KIND OF BUSINESS OR INDUSTRY TOBACCO INDUSTRY		11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME CARL PETERSON				14. MOTHER'S MAIDEN NAME CATHERINE REINERS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 381-12-5070		17. INFORMANT Gen. T. Allen Bennett		Address 2772 Ft. Scott Dr. Alex. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163 X IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA RIGHT LOWER LOBE DUE TO CARCINOMATOSIS PERITONAEUM, LIVER, MEDIASTINUM AND Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LEFT CEREBRUM DUE TO EPIDERMOID CARCINOMA LEFT UPPER LOBE LUNG										INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12 Nov to 6 Dec , 19 60 that (I) (we) last saw the deceased alive on 6 Dec , 19 60 , and that death occurred at 4:30 PM from the causes and on the date stated above.											
22a. SIGNATURE Edwin E. Westura				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6 Dec 60	
22c. PHYSICIAN'S NAME (Type) EDWIN E WESTURA, CAPT USAF (MC)				22d. ADDRESS USAF HOSP., ANDREWS AFB, WASH 25, D C							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-9-60		23c. NAME OF CEMETERY OR CREMATORY Detroit, Michigan		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi						ADDRESS 816 H St., NE, Wash. 2, DC		25a. REC'D BY REGISTRAR Dec 8 1960		25b. REGISTRAR'S SIGNATURE	

Two for One: FilmG277 12-19-60 et

14333

CERTIFICATE OF DEATH

Reg. Dist. No.

14278

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Rt 3, Box 500</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND HOSP. CENTER</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HENRY</u> Last <u>POETZMAN, III</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5- -59</u>	
9. AGE (In years last birthday) <u>1</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>1</u> Min. <u>17</u>		IF UNDER 24 HRS. Months <u>1</u> Days <u>17</u> Hours <u>1</u> Min. <u>17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Henry Poetzman, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Daisy M. Donald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>FATHER JOHN POETZMAN</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO <u>STRIKES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METABOLIC ACIDOSIS</u> DUE TO <u>3 DAYS</u> (c) <u>VIRAL GASTROENTERITIS-VOMITING AND DIARRHEA</u> DUE TO <u>5 DAYS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION LISTED IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>NONE</u> m. <u>19</u>				20d. INJURY OCCURRED While <u>NONE</u> Not while <u>NONE</u> of work <u>NONE</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>NONE</u>				20f. (City or town) <u>NONE</u> (County) <u>NONE</u> (State) <u>NONE</u>			
21. I certify that I attended the deceased from <u>DEC. 4, 1960</u> to <u>Present</u> , that I last saw the deceased alive on <u>12/17, 1960</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Branch Ave. Clinton, MD</u>			
DATE SIGNED <u>12/17/60</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>				ADDRESS <u>BRANCH AVE. CLINTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-20-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Em</u>				22d. LOCATION (City, town, or county) <u>Clinton, Md</u> (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>North Funeral Home</u>				ADDRESS <u>Waldorf, Md</u>			
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED
CLARK, J. H.
AGE
45 years

DATE OF DEATH
JAN 15 1904

PLACE OF DEATH
NEW YORK CITY

CAUSE OF DEATH
HEART DISEASE

SIGNATURE OF PHYSICIAN
J. H. CLARK

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14334
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14279

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Washington DC)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Rural (Washington D.C.)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7204 East Fort Foot Terrace</u>		d. STREET ADDRESS <u>6204 East Fort Foot Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Billingsley Garner Pogue</u>		4. DATE OF DEATH Month Day Year <u>December 17 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Parking Garage</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert Pogue</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Garner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-3292</u>	
17. INFORMANT Address <u>Mrs. Lillia Pogue, 7204 East Fort Foot Terrace</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peri carditis.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c) <u>Generalized Arterio sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>6 weeks</u> <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 30, 1960</u> , to <u>Dec. 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15, 1960</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Humphreys, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/17/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>		22d. ADDRESS <u>1746 K St. N.W., Wash. D.C.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 21-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Saints</u>		23d. LOCATION (City, town, or county) (State) <u>Capby, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Summer Bros</u> ADDRESS <u>1661 4th Ave S E Wash 20 200</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 20 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

CERTIFICATE OF DEATH

1913

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Signature of coroner

14335

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14280

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PRINCE GEORGE COUNTY</u> b. COUNTY <u>MD.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>3922 SUITLAND RD. SE. 1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD FRANKLIN POLEND JR.</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-26</u>		9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRMAN, V.A.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE REPAIRMAN</u>		11. BIRTHPLACE (State or foreign country) <u>DC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RICHARD FRANKLIN POLEND SR.</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MAY SNYDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NAVY</u> (If yes, give war or dates of service) <u>1945</u>				16. SOCIAL SECURITY NO. <u>578-28-7650</u>			
17. INFORMANT Address <u>MRS RICHARD F. POLEND 3922 Suitland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> (c) <u>DIABETES MELLITUS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>12/18/60</u> , that (I) (we) last saw the deceased alive on <u>12/18/60</u> , and that death occurred at <u>10:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Vincent P. Sweeney M.D.</u>				22b. DATE SIGNED <u>12/19/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>VINCENT P. SWEENEY M.D.</u>				22d. ADDRESS <u>1150 CONNECTICUT AVE. NW. DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661 - Good Hope Rd SE WASH, 20005</u>				25a. REC'D BY REGISTRAR <u>DATE DEC 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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14-00000

CERTIFICATE OF DEATH

14-00000

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

the within and foregoing is a true and correct copy of the

original certificate of death filed in my office on the 14th day of

April, 1914, at New York City, New York.

Witness my hand and the seal of my office, this 14th day of April, 1914.

Dr. J. H. [Name] [Signature]

My commission expires on the 14th day of April, 1915.

Attest: [Signature] [Name]

Notary Public for the State of New York.

United States District Court, Southern District of New York.

Filed for record this 14th day of April, 1914.

Attest: [Signature] [Name]

Notary Public for the State of New York.

1914

Attest: [Signature] [Name]

Notary Public for the State of New York.

Attest: [Signature] [Name]

Notary Public for the State of New York.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 14266 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14281

1. PLACE OF DEATH a. COUNTY Prince George's County, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly, Maryland c. LENGTH OF STAY IN 1b DOA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakcrest			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 408 Mulberry Street			
3. NAME OF DECEASED (Type or print) Reginald First Powell Middle Powell Last				4. DATE OF DEATH Month Dec. Day 29 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-60	
9. AGE (In years, last birthday) 2 mo. XX		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Howard Augusta Brooks				14. MOTHER'S MAIDEN NAME Lillian Ann Powell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Lillian Ann Powell, Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 525X Dehydration IMMEDIATE CAUSE (a) DUE TO Toxemia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Interstitial Pneumonia (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12-29-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 2 1961		22c. NAME OF CEMETERY OR CREMATORY Bacone Chapel		22d. LOCATION (City, town, or country) (State) Amesbury Md	
23. FUNERAL DIRECTOR Ridgely Selby 5-02 4th St Laurel				24a. REC'D BY REGISTRAR JAN 3 '61			
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

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Weyland

Weyland

408 Highway Street

James George's Garage Hospital

Towell

Weyland

2 No. 11

10-11-50

Colonel

Kale

Weyland

William Ann Wells

Robert's House Room

William Ann Wells, 2nd No. 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14267

14282

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City d. STREET ADDRESS 3712 Parkwood St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth E Pumphrey		4. DATE OF DEATH Month Day Year Dec. 13 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James S Lamkin		14. MOTHER'S MAIDEN NAME Sallie Craft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital record		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 434.1 IMMEDIATE CAUSE (a) Influenzal pneumonia DUE TO (b) congestive heart failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Stroke PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0		INTERVAL BETWEEN ONSET AND DEATH 36 hours. 24 hours 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 57 to Dec. 13 , 19 60 , that (I) (we) last saw the deceased alive on Dec. 13 , 19 60 and that death occurred on Dec. 13 from the causes and on the date stated above.			
22a. SIGNATURE Leon T. Levitsky M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Leon T. Levitsky, M.D.		22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REGISTER'S SIGNATURE DEC 20 '60	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14336

CERTIFICATE OF DEATH

14582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt #3, Box 207				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Howe Last Rawlings				4. DATE OF DEATH Month December Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1871	
9. AGE (In years last birthday) 89 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME James Henry Rawlings			
14. MOTHER'S MAIDEN NAME Martha Ann Wilson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Gladys W. Rawlings-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular - Renal Failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age DUE TO (c) Inanition				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 7/18/1959 to 12/19/1960 , that I last saw the deceased alive on 12/18/1960 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) Aquasco, Maryland				21. DATE SIGNED 12/20/60			
21. ACTUAL SIGNATURE V. M. Seron				21. M.D. V. M. Seron, M.D.			
21. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/60		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Baden Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro,				24a. REC'D BY REGISTRAR JAN 13 '61		24b. REGISTRAR'S SIGNATURE Charles S. Frank	

CERTIFICATE OF DEATH

1918

DEATH
REPORT
BY
MEDICAL
OFFICER

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Occupation	
Signature of Medical Officer		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	
Signature of Physician		Signature of Nurse		Signature of Undertaker	
Signature of Burial Officer		Signature of Cemetery		Signature of Funeral Home	
Signature of Health Officer		Signature of Board of Health		Signature of City Council	
Signature of Mayor		Signature of Governor		Signature of President	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel General Hospital Inc.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard County c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS #9 Williams e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
3. NAME OF DECEASED (Type or print) First REBECCA Middle VIRGINIA Last REDMOND						4. DATE OF DEATH Month Dec Day 31 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1897		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 13 Days x-2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY University of Md.				11. BIRTHPLACE (State or foreign country) Alberton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McElvaney						14. MOTHER'S MAIDEN NAME Annie Elizabeth Waskey					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-14-6377		17. INFORMANT Mr. Albert F. Miller,		Address Jessup, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/1/61			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 3 - 1961		22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		22d. LOCATION (City, town, or country) (State) Savage, Howard - Md					
23. FUNERAL DIRECTOR Arthur S. Kraus				ADDRESS Laurel Md		24a. REC'D BY REGISTRAR JAN 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14268
14284
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale	
3. NAME OF DECEASED (Type or print) First Allis Middle M. Last Reed		4. DATE OF DEATH Month December Day 20 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1876
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Mitchell		14. MOTHER'S MAIDEN NAME Allice Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Janet R. Gambrell (Daughter) Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 HOURS UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19 1960 , to 12-20 19 60 , that (I) (we) last saw the deceased alive on 12-20 19 60 , and that death occurred on 12-20 19 60 from the causes and on the date stated above.			
22a. SIGNATURE E. James Duke		22b. DATE SIGNED 12/21/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/60	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Waycross Ga.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DEC 23 '60	
ADDRESS Hyattsville, Maryland		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

STATE OF NEW YORK

14508

July 12, 1908

Alice Duvall

Henry Mitchell

James K. Mitchell

United Cemetery

1908/09

General

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14285											
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9109 Third Street						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 9020 Second Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) NORMAN McCLOUD REED						4. DATE OF DEATH Month December Day 18 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1920		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machanist				10b. KIND OF BUSINESS OR INDUSTRY Tool Maker				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman McCLOUD Reed						14. MOTHER'S MAIDEN NAME Florence Heitzman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II						16. SOCIAL SECURITY NO. unknown		17. INFORMANT Robert M. Hudlow,		Address 7504 West Park Drive Hyattsville, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound in right side of neck (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Shot while breaking into house					
20c. TIME OF INJURY Hour a.m. 1:00 PM 12/18 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Private House		20f. (City or town) Lanham, Prince Geo. Cty., Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 18, 1960.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 21, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or country) Suitland Md.		(State)			
23. FUNERAL DIRECTOR GASCH'S FUNERAL HOME, Hyattsville, Maryland.						24a. REC'D BY REGISTRAR DEC 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10-11-68

Prince Georges County

Prince Georges

Prince Georges

9100 Third Street

9020 Second Street

10-11-68

10-11-68

10-11-68

10-11-68

White

White

x

Washington

Washington

U.S.A.

Theresa Helman

Theresa Helman

NY 11

Robert W. Helman

Washington

Handbags and shoes

Quarantined wound in right side of neck

Shot while breaking into house

x

1:00 PM 12/18

x Private House

Prince Georges County, Md.

x

JAMES I. HOLT, M.D.

December 18, 1968

Dec 18, 1968 - when still unconscious

WYOMING, WYOMING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
14338
CERTIFICATE OF DEATH

14286

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Dist. of Columbia</i> b. COUNTY <i>Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Camp Springs</i>		c. LENGTH OF STAY IN 1b <i>26 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hosp. Andrews</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edwin</i> First <i>George</i> Middle <i>Reh Kemper</i> Last		4. DATE OF DEATH <i>December 24</i> Month <i>December</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cau</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11 DEC 1919</i>
9. AGE (In years last birthday) <i>41</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Armed Service</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>USAF</i>	
11. BIRTHPLACE (State or foreign country) <i>Oconee Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Herman G.</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Tammen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>1942-Present</i>		16. SOCIAL SECURITY NO. <i>572-21-2028</i>	
17. INFORMANT <i>Mrs. Helena Reh Kemper</i> Address <i>7820 Whitney Ave SE WASH 28 DC</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SEPTICEMIA</i> <i>572-2</i> DUE TO (b) <i>PERITONITIS</i> DUE TO (c) <i>ULCERATIVE COLITIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i> <i>13 Dec. 60</i> <i>APRIL 1960</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>23 Nov.</i> 19 <i>60</i> , to <i>24 Dec.</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>24 Dec.</i> 19 <i>60</i> , and that death occurred at <i>2:45 P.</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <i>12/24/60</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>12-29-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>PANA ILLINOIS</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>RINALDI FUNERAL HOME</i>		25a. REC'D BY REGISTRAR <i>DEC 27 '60</i>	
ADDRESS <i>816 Hst. N.E.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

CERTIFICATE OF DEATH

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At the County of ... State of ...

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14339 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 14287

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi, Md				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1802 Jasmine Terrace				d. STREET ADDRESS 1802 Jasmine Terrace			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES AUGUSTUS RIDLON				4. DATE OF DEATH Month Day Year December 15, 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 20, 1877	
9. AGE (In years lost birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Alfred B Ridlon				14. MOTHER'S MAIDEN NAME Mary A Goodwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Gladys Monroe				Address Adelphi, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH one hour 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Influenza							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 60 , to 12/15 , 19 60 , that I last saw the deceased alive on 12/13 , 19 60 , and that death occurred at 5⁰⁰ A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hugh W. Frey				ADDRESS (Street, city or town, state) M.D. 7105 - RIGGS RD			
PHYSICIAN'S NAME (Type) HUGH W. FREY				DATE SIGNED 12/15/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Ded 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 20 '60	
				24b. REGISTRAR'S SIGNATURE Clifton S. Harris			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 and 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14269

14288

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S GEN. HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH d. STREET ADDRESS 514 So. Spring Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) JAMES LEE ROGERS		4. DATE OF DEATH Month Dec. Day 27 Year 1960		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 27, 1918		9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5		11. IF UNDER 24 HRS. Hours 5 Min. 5			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER				10b. KIND OF BUSINESS OR INDUSTRY Condon-Reed, Inc				11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FRANK M. ROGERS				14. MOTHER'S MAIDEN NAME IDA MARY ROGERS nee FUGH				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 577-16-1171				17. INFORMANT TOMMY J. ROGERS, BEECH CRAFT DRIVE, ALEX., VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Artery Thrombosis DUE TO (c) Coronary Arteriosclerosis																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-27-60																			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.				Address (Street, city, town, or county) Washington National Suitland, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/30/60		22c. NAME OF CEMETERY OR CREMATORY Washington National				22d. LOCATION (City, town, or country) (State) Suitland, Maryland									
23. FUNERAL DIRECTOR W.W. CHAMBERS CO., ADDRESS Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE DEC 29 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Hume											

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13 1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
14297											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale D.O.A. c. LENGTH OF STAY IN Td d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Laurel d. STREET ADDRESS Lynnville Ave.					
3. NAME OF DECEASED (Type or print) LENORA First Middle Last 4. DATE OF DEATH Dec. 14 1960 Month Day Year						5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH April 16, 1904 9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switch Board Operator U.S. Dept. Agr. Govt. 11. BIRTHPLACE (State or foreign country) Laurel, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Clarence White 14. MOTHER'S MAIDEN NAME Evelyn Fisher					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 218-05-5180 17. INFORMANT Mrs Doris Rhoades Address 5607 Lacka. St., College Park, Md.						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pernicious anemia					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec 17, 1960 22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery 22d. LOCATION (City, town, or country) (State) Laurel, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Dec. 15, 1960 Address (Street, city, town, or county)					
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. 24a. REC'D BY REGISTRAR DEC 20 '60 24b. REGISTRAR'S SIGNATURE											

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VS. A1SME
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14290

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE	
Prince Georges County		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Lenham		36 Lenham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
9109 Third Street		/ 9109 Third Street	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
ANN MARIE ROSE		December 18, 1960.	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		April 9, 1919	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Clerk - Steog.		Washington, D. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Everett Lee Bono		Vivian Eulia Thorn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
Yes		unknown	
17. INFORMANT		Address	
James E. Bryan Jr.,		4504 Amherst Lane Bethesda, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Hemorrhage and shock	
781X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Gun shot wounds of chest, abdomen and right buttock.	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
		Shot in bedroom of home by person breaking into house.	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a.m. 12/18/ 1960		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
1:00 PM 12/18/ 1960		Private Home Lenham, Prince Georges Cty., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED	
		December 18, 1960.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/21/60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Arlington Co. Nat. Cem.		Arlington Va	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
CHEVY CHASE FUNERAL HOME, Ave., N.W., Wash. D.C.		DEC 23 '60	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Kraus	

RECEIVED
FBI
JAN 11 1960

1:00 PM
JAN 11 1960

9109 Third Street
JAN 11 1960

9109 Third Street
JAN 11 1960

December 18, 1959

April 9, 1960

Female White

U.S.A.

Washington, D. C.

U.S. Treasury

Clerk - Street

Vivian White House

Westport Lee House

1804 Adams Lane

Beltsville, Maryland

James E. Brown Jr.

unknown

Mr. H.

Yan

Removals and shots

This photograph of chest, abdomen and right
outlook.

Quadrant of nose by person residing into house.

JAN 11 1960

X Private Home

1:00 PM 2/18/ 60

X

JAN 11 1960

December 18, 1959

201 Washington

GRANT CHASE FEDERAL BANK, WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14341

CERTIFICATE OF DEATH

Reg. Dist. No. 14291

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest-Hadphi</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 1 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Trinity Branch Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> 58	
f. STREET ADDRESS <u>2410 Newisdale Tr.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MADGE</u> Middle <u>RYCE</u> Last <u>RYCE</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive housekeeper</u>		12. KIND OF BUSINESS OR INDUSTRY <u>St. E's Hospital</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Henry Lyon</u>		16. MOTHER'S MAIDEN NAME <u>Joanna Herbert</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>577-38-9992</u>	
19. INFORMANT <u>MARY E. MEYER (Daughter)</u>		Address <u>As above</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Vagina & Metastasis</u> DUE TO <u>176.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>176.1</u> DUE TO (c) <u>176.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Repeated Urinary Infections</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-16</u> , 19 <u>60</u> , to <u>12-21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12-13</u> , 19 <u>60</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Avenue</u> DATE SIGNED <u>12-21-60</u>	
PHYSICIAN'S NAME (Type) <u>STUART L. Nelson, M.D.</u>		Address <u>Takoma Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G276 12-13-60 et

CERTIFICATE OF DEATH

14270

Reg. Dist. No.

14292

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> D. C. b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad-Sacreda Nursing Home</u>		d. STREET ADDRESS <u>Linsey St., S. E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucenda PUGH SALE</u>		4. DATE OF DEATH Month Day Year <u>Dec 2 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1871</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOS. PUGH</u>		14. MOTHER'S MAIDEN NAME <u>MARY THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>605 20th St. BROOKLYN, N.Y.</u>	
17. INFORMANT <u>ERNEST L. SALE</u>		Address <u>605 20th St. BROOKLYN, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/9</u> , 19 <u>60</u> , to <u>12/2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>60</u> , and that death occurred at <u>3:50 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comaul</u>		ADDRESS (Street, city or town, state) <u>3503 Penny St</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMAUL</u>		DATE SIGNED <u>12/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BOWLING GREEN, VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Manner</u>		ADDRESS <u>VA.</u>	
24a. REC'D BY REGISTRAR <u>DEC 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneale</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14293

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 4 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mitchellville		d. STREET ADDRESS Mitchellville Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Abraham		First None Middle None Last Scribner		4. DATE OF DEATH Month 12 Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1908	
9. AGE (in years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 05 Days 05		IF UNDER 24 HRS. Hours 05 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edward Scribner				14. MOTHER'S MAIDEN NAME Harriette Oden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If any give year or dates of service)		17. INFORMANT Louise Scribner		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEVERE MALNUTRITION AND DEHYDRATION						INTERVAL BETWEEN ONSET AND DEATH 	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. James I. Boyd		Address (Street, city, town, or county)		DATE SIGNED 12/24/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-60		22c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		22d. LOCATION (City, town, or country) (State) Huntsville, Md.	
23. FUNERAL DIRECTOR Myrtle K. Rollins		ADDRESS Washington 19, D.C.		24a. REC'D BY REGISTRAR DEC 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

VS. AISM
5M 7/59

100-111
100-111

James George's

Wayland

James George's

University

James

Wayland

James George's (small hospital)

Wayland

James

Wayland

James

James George's (small hospital)

Wayland

James George's

James

Wayland

James

James George's

Wayland

James George's

James George's

James George's

X

James I. George

James I. George

James I. George

James I. George

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14272 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14294

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Hospital				d. STREET ADDRESS Ritchie Road, Box 1800			
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last SELLMAN				4. DATE OF DEATH Month Dec Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1960	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Horace Sellman				14. MOTHER'S MAIDEN NAME Doris Ellis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Horace Sellman				Address Box 1800, Ritchie Road, Upper Marlboro, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/11/60							
ACTUAL SIGNATURE James I. Boyd				EXAMINER'S NAME (Type) James I. Boyd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-60		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR John T. Phinnes + Co				ADDRESS 3015-14 St NE, Washington D.C.			
24a. REC'D BY REGISTRAR DEC 15 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

VS. A15ME
5M 959

James C. G. Thompson

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• 2007

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14273
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14295

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>7 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>1431 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>Smith, Sr</u> Middle Last		4. DATE OF DEATH <u>Dec</u> Month <u>19</u> Day <u>1960</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1888</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>S. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dennis Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jessie Smith - Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (right fronto-parietal)</u> DUE TO <u>Mural Thrombus secondary to myocardial infarction</u> Occlusion of right coronary artery (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO <u>lying cause lost.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 week</u> <u>1 week</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12, 1960</u> to <u>Dec. 19, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 19, 1960</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur L. Crossgreen</u>		22b. DATE SIGNED <u>12/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRVIN M. GRASSGREEN MD</u>		22d. ADDRESS <u>5101 ARUNDEL RD MIT. RAINIER MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-24-60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Carver Park</u>		23d. LOCATION (City, town, or county) (State) <u>Murksboro Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1960</u>	
ADDRESS <u>4925 D Lane Gm 115</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Crossgreen</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 44		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 4203 Newark Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANCY		First KATHERINE		Middle SMITH		Last		4. DATE OF DEATH December 3, 1960.		9. AGE (In years last birthday) 79 yrs.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1881		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Whiteville, N. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William James McGirt				14. MOTHER'S MAIDEN NAME Julia Ward				17. INFORMANT Mrs. John W. Bright,			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				Address 4203 Newark Street Colmar Manor, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute congestive heart failure											
DUE TO (b) Cardiovascular renal disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Sea Gate Cemetery		22d. LOCATION (City, town, or country) Wilmington, North Carolina.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland.		24a. REC'D BY REGISTRAR DEC 8 '60		DATE		24c. CHIEF MEDICAL EXAMINER JAMES I. BOYD, M. D.	
24d. DEPUTY MEDICAL EXAMINER				24e. DATE SIGNED December 3, 1960.		24f. CHIEF MEDICAL EXAMINER		24g. ASSISTANT MEDICAL EXAMINER		24h. DEPUTY MEDICAL EXAMINER	

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077

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2

100-100000

100-100000

Prince Georges County Maryland
Chesley
Colman Henry

Prince Georges County Maryland
300 Howard Street

Female White X
Dec. 18, 1901
WV

Housewife At Home
Whiteville, N. C.

William James McGill
John V. Wright
Colman Henry, Maryland

none on active head failure

Chloroanular renal disease

X X X

December 2, 1900
James I. Boyd, M.D.

Dec. 5, 1900 See Gate Cemetery
Washington, North Carolina
W. V. GORDON CO., Nashville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14275

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14297

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg 40			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 4103 46th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Spriggs Last				4. DATE OF DEATH Month December Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-22-98		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANCIS SPRIGGS				14. MOTHER'S MAIDEN NAME MARY A. HENRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-27-10		17. INFORMANT MRS. ISABELLE R. HAMILTON-131-Y ST. N. W., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 3403 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Purulent Meningitis (organism undetermined) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to Dec. 13, 1960 that (I) (we) last saw the deceased alive on Dec. 13, 1960, and that death occurred at 10:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Chas. David Connor, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 12-14-60	
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connor, M.D.				22d. ADDRESS 5813 Landover Road, Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 17, 1960		23c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL PARK		23d. LOCATION (City, town, or county) (State) WASH-BALTIMORE BLVD-MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Robinson				ADDRESS 1313-6 St. N. W. D.C.		25a. REC'D BY REGISTRAR DATE DEC 19 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Bop

1237

RECORDS OF DEATH

MARYLAND

MARY A HENRY

FRANCIS SPRINGS

USA

STATE OF MARYLAND R. HANCOCK COUNTY

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14298											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Mem. Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria d. STREET ADDRESS 1954 Oak Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George Thornton STANTON						4. DATE OF DEATH Month Dec Day 20 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 May 1900		9. AGE (in years last birthday) 60		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman (Ret)				10b. KIND OF BUSINESS OR INDUSTRY Metro. Police Dept				11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Stanton						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT Address Ethel P. Stanton (Wife) Same as # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Abdominal Hemorrhage 904.0 DUE TO Rupture Splenic Vein Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Trauma of Fall (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced Cirrhosis and Portal Hypertension											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidental Fall							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lawn		20f. (City or town) (County) (State) Hyattsville, Prince George, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/20/1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-23-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				22d. LOCATION (City, town, or country) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR Wm. Demaine & Son Funeral Home, Alexandria, Va.						24a. REC'D BY REGISTRAR DATE DEC 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kruus			

11-22-58 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Deceased: James I. Wolf White Male 21 May 1930

Place of Birth: Wetzelville W. Va.

Residence: 1054 Oak Drive Wetzelville

Occupation: George Thompson STATION 21 May 1930

Cause of Death: Police Dept. West Virginia

Place of Death: Charm

Age: U.S. 1 James I. Wolf Station (Wife) 21 May 1930

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

Signature: James I. Wolf

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

14276

14299

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 mo. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle Benjamin Last Stine				4. DATE OF DEATH Month December Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1905	
9. AGE (In years lost birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draw Bridge Operator		10b. KIND OF BUSINESS OR INDUSTRY St. of Md.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Stine		14. MOTHER'S MAIDEN NAME Maria L. Farrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-28-3574		17. INFORMANT Mrs. Ann C. Stine - Hillcrest Heights, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, larynx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 7 yr.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from Nov. 11 19 60 to Dec. 26 19 60 , that (I) (we) last saw the deceased alive on Dec. 26 19 60 , and that death occurred 10:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Chas. David Connor, M.D.				22b. DATE SIGNED 12-27-60			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connor, M.D.				22d. ADDRESS 5813 Landover Rd. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/1960		23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		23d. LOCATION (City, town, or county) (State) Issue, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard Funeral Home, Inc., Baltimore, Md.				25a. REC'D BY REGISTRAR DEC 30 '60		25b. REGISTRAR'S SIGNATURE C. S. K...	

1182

CHIEF KATE OF TEATH

1878

[Faint, mostly illegible handwritten text, possibly a ledger or account book. Some words like "CHIEF KATE OF TEATH" and "1878" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS 2814 6th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle Sullivan Last Sullivan		4. DATE OF DEATH Month 12/2/60 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/1899
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration	
11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Busey		14. MOTHER'S MAIDEN NAME Eva Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT George William Sullivan		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 2° DUE TO Ovarian Carcinoma Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Ovarian Carcinoma (c) Ovarian Carcinoma			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 11 19 60 to Nov 2 19 60 that (I) was lost saw the deceased alive on Nov 2 19 60 and that death occurred at 8:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED Nov 2/1960	
22c. PHYSICIAN'S NAME (Type) Harry N Carlton		22d. ADDRESS 940-25th St, N.W. Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 6, 1960	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		25a. REC'D BY REGISTRAR DEC 7 '60	
25b. REGISTRAR'S SIGNATURE Curtis L. Krawch			

1899

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14301											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE'S GENERAL HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARMODY HILLS d. STREET ADDRESS 317 CARMODY HILLS DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM JOSEPH TAFT						4. DATE OF DEATH Month Day Year DEC. 26 1960					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 19, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CONN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE TAFT						14. MOTHER'S MAIDEN NAME UNKNOWN Mary					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO						16. SOCIAL SECURITY NO. 579 09 6506		17. INFORMANT CLARENCE W. TAFT		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (e), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
12a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						12b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE JAMES I. BOYD, M.D. EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Arthur L. Hanna					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12.30.1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				22d. LOCATION (City, town, or country) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR ADDRESS Lee.Funeral.Home. 300.4th.st N E.Wash.						24a. REC'D BY REGISTRAR DATE DEC 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

RECEIVED
JUL 11 1963

1963 MEDICAL EXAMINATION CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]
DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]
DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE OF PHYSICIAN: [REDACTED]
DATE: [REDACTED]

1

Continued from front of certificate

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]
7. [REDACTED]
8. [REDACTED]
9. [REDACTED]
10. [REDACTED]
11. [REDACTED]
12. [REDACTED]
13. [REDACTED]
14. [REDACTED]
15. [REDACTED]
16. [REDACTED]
17. [REDACTED]
18. [REDACTED]
19. [REDACTED]
20. [REDACTED]
21. [REDACTED]
22. [REDACTED]
23. [REDACTED]
24. [REDACTED]
25. [REDACTED]
26. [REDACTED]
27. [REDACTED]
28. [REDACTED]
29. [REDACTED]
30. [REDACTED]
31. [REDACTED]
32. [REDACTED]
33. [REDACTED]
34. [REDACTED]
35. [REDACTED]
36. [REDACTED]
37. [REDACTED]
38. [REDACTED]
39. [REDACTED]
40. [REDACTED]
41. [REDACTED]
42. [REDACTED]
43. [REDACTED]
44. [REDACTED]
45. [REDACTED]
46. [REDACTED]
47. [REDACTED]
48. [REDACTED]
49. [REDACTED]
50. [REDACTED]
51. [REDACTED]
52. [REDACTED]
53. [REDACTED]
54. [REDACTED]
55. [REDACTED]
56. [REDACTED]
57. [REDACTED]
58. [REDACTED]
59. [REDACTED]
60. [REDACTED]
61. [REDACTED]
62. [REDACTED]
63. [REDACTED]
64. [REDACTED]
65. [REDACTED]
66. [REDACTED]
67. [REDACTED]
68. [REDACTED]
69. [REDACTED]
70. [REDACTED]
71. [REDACTED]
72. [REDACTED]
73. [REDACTED]
74. [REDACTED]
75. [REDACTED]
76. [REDACTED]
77. [REDACTED]
78. [REDACTED]
79. [REDACTED]
80. [REDACTED]
81. [REDACTED]
82. [REDACTED]
83. [REDACTED]
84. [REDACTED]
85. [REDACTED]
86. [REDACTED]
87. [REDACTED]
88. [REDACTED]
89. [REDACTED]
90. [REDACTED]
91. [REDACTED]
92. [REDACTED]
93. [REDACTED]
94. [REDACTED]
95. [REDACTED]
96. [REDACTED]
97. [REDACTED]
98. [REDACTED]
99. [REDACTED]
100. [REDACTED]

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please submit the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

199

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14302											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Mt. Rainier				d. STREET ADDRESS 3358 Chillum Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES AGNES THOLL						4. DATE OF DEATH Month Day Year December 28, 1960.					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1913		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Cashier				10b. KIND OF BUSINESS OR INDUSTRY At Home - C&P				11. BIRTHPLACE (State or foreign country) Kingsport, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Bernard Moats						14. MOTHER'S MAIDEN NAME Ada B. Trimble					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 597-01-9202					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None						17. INFORMANT yes, unknown Arthur J. Tholl, Road, Mount Rainier, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Pulmonary hemorrhage (b) acute bronchitis (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis											
12a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				12b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						Address (Street, city, town, or county) 12/28/1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/31/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or country) Washington, D.C.			
23. FUNERAL DIRECTOR Nalley's Funeral Home, Inc.						ADDRESS Mt. Rainier, Md.		24e. REC'D BY REGISTRAR DATE JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Prison Hospital
Very Sick
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

Prison Hospital
J. J. White
Prison Hospital, General Hospital
1928-1929

14290

CERTIFICATE OF DEATH

Reg. Dist. No. 14303

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farm Mount-Hgts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farm Mount Hgts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>708-59-arr.</u>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>TOWLES</u> Middle Last		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV-14-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington-D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>Edward Towles</u>		14. MOTHER'S MAIDEN NAME <u>Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Frances B. Towles wife</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-17</u> , 19 <u>50</u> to <u>12-30</u> , 19 <u>60</u> that I last saw the deceased alive on <u>12-30</u> , 19 <u>60</u> , and that death occurred at <u>9:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Beeson</u>		ADDRESS (Street, city or town, state) <u>4423- Hunt Pl. NE</u>	
PHYSICIAN'S NAME (Type) <u>H. B. Beeson, M.D.</u>		DATE <u>1-4-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-4-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry S. Washington & Son</u>		24a. REC'D BY REGISTRAR <u>4925 Clean One</u>	
24b. REGISTRAR'S SIGNATURE <u>7-2</u>		DATE <u>1-4-61</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

14590

CENTRAL OF TEXAS

WALL PAPER STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14280

CERTIFICATE OF DEATH

14304

Item 9 Film 6277 12-29-60 et

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 708 Philadelphia Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Valentine		4. DATE OF DEATH Month Day Year Dec. 23 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1865	
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ruder		14. MOTHER'S MAIDEN NAME Maria ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mildred M. Weil		Address Wash. 28, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Peritonitis, generalized, and DUE TO 450-8 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) ② Malnutrition DUE TO 3 months. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 21 8:15 A.M. to Dec. 23 1960 that (I) (we) last saw the deceased alive on Dec. 23 1960, and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Connor, M.D.		22b. DATE SIGNED 12-23-60	
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connor, M.D.		22d. ADDRESS 5813 Landover Road, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Dupont		23b. DATE THEREOF 12/24/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Sulland Pk. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Simon Bros.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 1801 Good Hope Rd. SE Wash. D.C.		DATE DEC 27 '60	

14280
CERTIFICATE OF DEATH

State of New York
County of ...
City of ...

On this ... day of ... 19...

I, the undersigned, a duly qualified ...

do hereby certify that ...

... of the County of ...

... of the City of ...

... of the State of New York

... of the County of ...

... of the City of ...

... of the State of New York

... of the County of ...

... of the City of ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Fletcherstown		c. LENGTH OF STAY IN 1b		X		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Fletcherstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Box 215 Bowie, Md		d. STREET ADDRESS		Box 215 Bowie, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		Sherrell Joseph		Walker		4. DATE OF DEATH		December 24		1960	
5. SEX		M		6. COLOR OR RACE		Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH		January 21/56	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday)		4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		None		10b. KIND OF BUSINESS OR INDUSTRY		None		11. BIRTHPLACE (State or foreign country)		Maryland	
13. FATHER'S NAME		Sjerrell Walker		14. MOTHER'S MAIDEN NAME		Sarah Savoy		12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Address	
								Sherrell Walker, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal charring burns of the body 915.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
12a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		12b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of house that burned down									
20c. TIME OF INJURY Month, Day, Year 10:00 p.m. 12/24/1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Fletcherstown		(County) P. G.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		James I. Boyd						M.D.		DATE SIGNED	
EXAMINER'S NAME (Type)		James I. Boyd						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)			
		12-29-60		Church of Ascension		Bowie		Md.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Henry Washington + Son		4925 Neane Ave		DATE DEC 29 '60		Arthur S. Kraus					

RECEIVED BY THE DEPARTMENT OF THE ARMY
WASHINGTON, D. C. 20315
JAN 14 1945

George Washington University
Washington, D. C.

Washington, D. C.
Box 215, N.W.

George Washington University
Washington, D. C.

U. S. A.
George Washington University

George Washington University
Washington, D. C.

George Washington University

George Washington University
Washington, D. C.

George Washington University
Washington, D. C.

General director

14343

14306

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 9 months & 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X	
d. STREET ADDRESS 434 Newton Pl., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arden Middle L. Last Waller		4. DATE OF DEATH Month 12 Day 1 Year 19 60	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/41	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Federal Communication	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Waller		14. MOTHER'S MAIDEN NAME Hildred Dickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-56-4974	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/25/1960 to 12/1/1960, that (I) (we) last saw the deceased alive on 12/1/1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/1/1960	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-2-62 Nat. Harmony Co.		23b. DATE THEREOF 12-2-62	
23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Co.		23d. LOCATION (City, town, or county) (State) Prince Georges	
24. FUNERAL DIRECTOR'S SIGNATURE J. L. Lowe		25. REC'D BY REGISTRAR DEC 5 '60	
26. REGISTRAR'S SIGNATURE Arthur S. Kraus		27. REGISTRAR'S SIGNATURE	

STATE OF TEXAS

1911

SECTION

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CERTIFICATE OF DEATH

Reg. Dist. No.

14226

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>				c. LENGTH OF STAY IN 1b <u>46 Brentwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3705 TAYLOR ST.</u>				d. STREET ADDRESS <u>3705 TAYLOR ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ambrose</u> Middle <u>J.</u> Last <u>Walsh</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/21, 1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad mail service</u>			
11. BIRTHPLACE (State or foreign country) <u>DuShore, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>6009-10th Pl. Chillum, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb</u> , 1953, to <u>Dec 9</u> , 1960, that I last saw the deceased alive on <u>Dec 9</u> , 1960, and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Pomeroy</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Pennycu</u> DATE SIGNED <u>12/9/60</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT POMEROY</u>				MT RAINIER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home, Md.</u>				ADDRESS <u>Mt. Rainier</u>		REC'D BY REGISTRAR DATE <u>DEC 14 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11250

NOV 12 1964

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

1 the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14281

14308

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 52 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1 3507 Bunkerhill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle F. Last Waters				4. DATE OF DEATH Month December Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Feb 1884	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Torpedo Plant, Alex. Va.				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Fuller Waters				14. MOTHER'S MAIDEN NAME Enoa Showacher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT William J. Waters, Son Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X Cerebral Rh. Myel. DUE TO (b) Carcinoma (Bronchogenic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) of lungs DUE TO (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-12-60 19 60 , to Dec. 3 19 60 , that (I) (we) last saw the deceased alive on Dec. 2 19 60 , and that death occurred at 1:40 AM from the causes and on the date stated above.							
22a. SIGNATURE Hans Wodak				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 4, 1960	
22c. PHYSICIAN'S NAME (Type) HANS WODAK M.D.				22d. ADDRESS 9-E PARKWAY GREENBELT, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt. Rainier, Md.				ADDRESS Nalley's Funeral Home, Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE DEC 7 '60	
				25b. REGISTRAR'S SIGNATURE William S. Frank			

STATE OF TEXAS

1881

F.

Green Water
William J. Water, born
Tulsa, Oklahoma, 1881

1881

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14282

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14309

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ADA Ada First Middle Last				4. DATE OF DEATH Dec. 18 1960 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1874	
9. AGE (In years lost birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Goings				14. MOTHER'S MAIDEN NAME Louise Cogan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hugh H. Hartley-1332-A. st S.E. (Nephew) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Fracture right hip. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture right hip. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 25 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home, Nov. 23, 1960					
20c. TIME OF INJURY Month, Day, Year 11-23-60 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) 4302 Monroe St. Brentwood Md.	
21. I certify that (I) (this hospital) attended the deceased from Nov. 23 1960 to Dec. 18 1960 , that (I) (we) lost the deceased alive on Dec. 19 1960 and that death occurred at 4:20 AM from the causes and on the date stated above.							
22a. SIGNATURE Frank H. Crossgreen				22b. DATE SIGNED 12-18-60			
22c. PHYSICIAN'S NAME (Type) FRANK M. GRASSGREEN M.D.				22d. ADDRESS 3701 ARUNDEL RD MTRAINER, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-60		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill		23d. LOCATION (City, town, or county) (State) Alexandria, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS Washington, D.C.				25a. REC'D BY REGISTRAR DATE DEC 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11283

CERTIFICATE OF GRADE

THE BOARD OF GRADE

OF THE DISTRICT OF COLUMBIA

DO HEREBY CERTIFY THAT

THE FOLLOWING IS A TRUE AND CORRECT

REPRODUCTION OF THE ORIGINAL

RECORD OF THE DISTRICT OF COLUMBIA

FOR THE YEAR 1900

AND IS A TRUE AND CORRECT

REPRODUCTION OF THE ORIGINAL

RECORD OF THE DISTRICT OF COLUMBIA

FOR THE YEAR 1900

AND IS A TRUE AND CORRECT

REPRODUCTION OF THE ORIGINAL

RECORD OF THE DISTRICT OF COLUMBIA

FOR THE YEAR 1900

ONE COPY

TO THE

LIBRARY

OF THE

DISTRICT OF COLUMBIA

FOR THE YEAR 1900

AND IS A TRUE AND CORRECT

REPRODUCTION OF THE ORIGINAL

RECORD OF THE DISTRICT OF COLUMBIA

FOR THE YEAR 1900

AND IS A TRUE AND CORRECT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14310

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prin Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MOUNT RAINIER</u> 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4204-34th ST.</u>		d. STREET ADDRESS <u>4204-34th ST.</u> 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>B.</u> Last <u>WEBB</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 25, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING INDUSTRY</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>HORATIO T. WEBB</u>		14. MOTHER'S MAIDEN NAME <u>VICTORIA UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>233-28-8432</u>	
17. INFORMANT <u>SARAH V. ARMSTRONG</u>		Address <u>4204-34th ST. MT. RAINIER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION (ASPHYXIATION)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASPIRATION OF GASTRIC CONTENTS</u> DUE TO (c) <u>CEREBRAL VASCULAR ACCIDENT, THROMBOSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>MINUTES</u> <u>WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROSIS, CHRONIC PULMONARY EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2</u> , 19 <u>60</u> , to <u>DEC. 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov. 25</u> , 19 <u>60</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin B. Bort</u>		ADDRESS (Street, city or town, state) <u>5115 S. DAKOTA AVE., S.E.</u>	
PHYSICIAN'S NAME (Type) <u>Wm. O.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HAYDEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAYDEN ALABAMA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home Inc. 816 H St. N.E. DC 2</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

CERTIFICATE OF DEATH

11221

<p>1. Name of deceased: James T. Reed</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: June 12, 1910</p>		<p>4. Place of birth: St. Louis, Mo.</p>	
<p>5. Date of death: June 12, 1910</p>		<p>6. Place of death: St. Louis, Mo.</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Name of physician: Dr. J. M. Reed</p>		<p>10. Name of funeral home: James T. Reed</p>	
<p>11. Name of informant: James T. Reed</p>		<p>12. Name of informant: James T. Reed</p>	
<p>13. Name of informant: James T. Reed</p>		<p>14. Name of informant: James T. Reed</p>	
<p>15. Name of informant: James T. Reed</p>		<p>16. Name of informant: James T. Reed</p>	
<p>17. Name of informant: James T. Reed</p>		<p>18. Name of informant: James T. Reed</p>	
<p>19. Name of informant: James T. Reed</p>		<p>20. Name of informant: James T. Reed</p>	
<p>21. Name of informant: James T. Reed</p>		<p>22. Name of informant: James T. Reed</p>	
<p>23. Name of informant: James T. Reed</p>		<p>24. Name of informant: James T. Reed</p>	
<p>25. Name of informant: James T. Reed</p>		<p>26. Name of informant: James T. Reed</p>	
<p>27. Name of informant: James T. Reed</p>		<p>28. Name of informant: James T. Reed</p>	
<p>29. Name of informant: James T. Reed</p>		<p>30. Name of informant: James T. Reed</p>	
<p>31. Name of informant: James T. Reed</p>		<p>32. Name of informant: James T. Reed</p>	
<p>33. Name of informant: James T. Reed</p>		<p>34. Name of informant: James T. Reed</p>	
<p>35. Name of informant: James T. Reed</p>		<p>36. Name of informant: James T. Reed</p>	
<p>37. Name of informant: James T. Reed</p>		<p>38. Name of informant: James T. Reed</p>	
<p>39. Name of informant: James T. Reed</p>		<p>40. Name of informant: James T. Reed</p>	
<p>41. Name of informant: James T. Reed</p>		<p>42. Name of informant: James T. Reed</p>	
<p>43. Name of informant: James T. Reed</p>		<p>44. Name of informant: James T. Reed</p>	
<p>45. Name of informant: James T. Reed</p>		<p>46. Name of informant: James T. Reed</p>	
<p>47. Name of informant: James T. Reed</p>		<p>48. Name of informant: James T. Reed</p>	
<p>49. Name of informant: James T. Reed</p>		<p>50. Name of informant: James T. Reed</p>	
<p>51. Name of informant: James T. Reed</p>		<p>52. Name of informant: James T. Reed</p>	
<p>53. Name of informant: James T. Reed</p>		<p>54. Name of informant: James T. Reed</p>	
<p>55. Name of informant: James T. Reed</p>		<p>56. Name of informant: James T. Reed</p>	
<p>57. Name of informant: James T. Reed</p>		<p>58. Name of informant: James T. Reed</p>	
<p>59. Name of informant: James T. Reed</p>		<p>60. Name of informant: James T. Reed</p>	
<p>61. Name of informant: James T. Reed</p>		<p>62. Name of informant: James T. Reed</p>	
<p>63. Name of informant: James T. Reed</p>		<p>64. Name of informant: James T. Reed</p>	
<p>65. Name of informant: James T. Reed</p>		<p>66. Name of informant: James T. Reed</p>	
<p>67. Name of informant: James T. Reed</p>		<p>68. Name of informant: James T. Reed</p>	
<p>69. Name of informant: James T. Reed</p>		<p>70. Name of informant: James T. Reed</p>	
<p>71. Name of informant: James T. Reed</p>		<p>72. Name of informant: James T. Reed</p>	
<p>73. Name of informant: James T. Reed</p>		<p>74. Name of informant: James T. Reed</p>	
<p>75. Name of informant: James T. Reed</p>		<p>76. Name of informant: James T. Reed</p>	
<p>77. Name of informant: James T. Reed</p>		<p>78. Name of informant: James T. Reed</p>	
<p>79. Name of informant: James T. Reed</p>		<p>80. Name of informant: James T. Reed</p>	
<p>81. Name of informant: James T. Reed</p>		<p>82. Name of informant: James T. Reed</p>	
<p>83. Name of informant: James T. Reed</p>		<p>84. Name of informant: James T. Reed</p>	
<p>85. Name of informant: James T. Reed</p>		<p>86. Name of informant: James T. Reed</p>	
<p>87. Name of informant: James T. Reed</p>		<p>88. Name of informant: James T. Reed</p>	
<p>89. Name of informant: James T. Reed</p>		<p>90. Name of informant: James T. Reed</p>	
<p>91. Name of informant: James T. Reed</p>		<p>92. Name of informant: James T. Reed</p>	
<p>93. Name of informant: James T. Reed</p>		<p>94. Name of informant: James T. Reed</p>	
<p>95. Name of informant: James T. Reed</p>		<p>96. Name of informant: James T. Reed</p>	
<p>97. Name of informant: James T. Reed</p>		<p>98. Name of informant: James T. Reed</p>	
<p>99. Name of informant: James T. Reed</p>		<p>100. Name of informant: James T. Reed</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Spring d. STREET ADDRESS 5202 Stanhaven Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Daniel James WERT			4. DATE OF DEATH Month Dec Day 31 Year 1960						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 17, 1960		9. AGE (in years last birthday) yrs. 1 Months 15 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas F. Wert Jr					14. MOTHER'S MAIDEN NAME Dorthea Green				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Frederick Wert Jr. same as # 2 Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL LOBULAR PNEUMONIA 490x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. 								INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/31/60		
EXAMINER'S NAME (Type) James I. Boyd			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-4-1961		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) Arlington, Va.			
23. FUNERAL DIRECTOR James T. Ryan, Inc.				24a. REC'D BY REGISTRAR 317 Pa. Ave., SE DC		24b. REGISTRAR'S SIGNATURE Charles S. Kneass			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14312

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISABELLE MILLER WHITE</u>		4. DATE OF DEATH Month Day Year <u>DEC. 31 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 24, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POST CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DISTRICT GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE H. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>JULIA T. McAVOY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MARGARET W. McCUSKEY</u> Address <u>6323 Luzon Ave WASH. D.C. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO <u>Chronic Nephritis with uremia</u> (c) <u>Undetermined</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Undetermined Undetermined Undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage (old 1959)</u> <u>Fracture Right Hip (old 1959)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>48</u> , to <u>Dec 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>60</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Dec 31, 1960</u>	
PHYSICIAN'S NAME (Type) <u>George L Ball</u>		DATE SIGNED <u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify by) <u>burial</u>		22b. DATE THEREOF <u>1/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14313

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines c. LENGTH OF STAY in 1b 7 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6316 Paterson Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines d. STREET ADDRESS 6316 Paterson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Percy William White		4. DATE OF DEATH Month 12 Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1896
9. AGE (In years, last birthday) 64		IF UNDER 1 YEAR Months 12 Days 20	IF UNDER 24 HRS. Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel White	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Kenneth W. White 2029 Rosemont Ave N. W., Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 442x		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/21/60	
EXAMINER'S NAME (Type) James I. Boyd		Address (Street, city, town, or county) Washington National Cemetery Suitland, Maryland.	
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial		26b. DATE THEREOF Dec. 23, 1960	
26c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		26d. LOCATION (City, town, or country) (State) Suitland, Maryland.	
27. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Maryland.		28. REC'D BY REGISTRAR DEC 27 '60	
29. REGISTRAR'S SIGNATURE Arthur L. Kneal			

VS. A15ME
5M 7/59

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Dates 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WASHINGTON STATE DEPARTMENT OF HEALTH
 DIVISION OF PUBLIC HEALTH AND PREVENTION
 1414 1st Avenue, Seattle, Washington 100

NAME	DATE	AGE	SEX	RACE	RELIGION	EDUCATION	OCCUPATION	RESIDENCE	DATE OF BIRTH	DATE OF DEATH	CAUSE OF DEATH	PLACE OF DEATH	DATE OF BURIAL	PLACE OF BURIAL
James I. Boyd	Dec. 27, 1960	27	M	White	Methodist	High School	Unemployed	1414 1st Avenue, Seattle, Washington 100	Dec. 27, 1960	Dec. 27, 1960	Heart Failure	Seattle, Washington	Dec. 27, 1960	Seattle, Washington
James I. Boyd	Dec. 27, 1960	27	M	White	Methodist	High School	Unemployed	1414 1st Avenue, Seattle, Washington 100	Dec. 27, 1960	Dec. 27, 1960	Heart Failure	Seattle, Washington	Dec. 27, 1960	Seattle, Washington
James I. Boyd	Dec. 27, 1960	27	M	White	Methodist	High School	Unemployed	1414 1st Avenue, Seattle, Washington 100	Dec. 27, 1960	Dec. 27, 1960	Heart Failure	Seattle, Washington	Dec. 27, 1960	Seattle, Washington
James I. Boyd	Dec. 27, 1960	27	M	White	Methodist	High School	Unemployed	1414 1st Avenue, Seattle, Washington 100	Dec. 27, 1960	Dec. 27, 1960	Heart Failure	Seattle, Washington	Dec. 27, 1960	Seattle, Washington
James I. Boyd	Dec. 27, 1960	27	M	White	Methodist	High School	Unemployed	1414 1st Avenue, Seattle, Washington 100	Dec. 27, 1960	Dec. 27, 1960	Heart Failure	Seattle, Washington	Dec. 27, 1960	Seattle, Washington

CERTIFICATE OF DEATH

Reg. Dist. No.

14314

14345

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Va</u> b. COUNTY <u>Woodrow</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>				c. LENGTH OF STAY IN 1b <u>2 mo. 1 wk.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pratt Branch Nursing Home</u>				d. STREET ADDRESS <u>834</u>			
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>(none)</u> Middle <u>Wickes</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1904</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min.		11. IF UNDER 24 HRS. Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Index of bookmobile</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>County</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Eugene Staples</u>				14. MOTHER'S MAIDEN NAME <u>Mae L. Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>229-44-8079</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
17c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				17d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
17e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				17f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>OCT. 21</u> , 19 <u>60</u> , to <u>DEC. 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>DECEMBER 13, 1960</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morrill C. Zunnem Jr</u>				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12-28-60</u>			
PHYSICIAN'S NAME (Type) _____				_____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Lincoln, Va.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>4739 Balt. Ave, Hyattsville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>				_____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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James J. Jones

1917 - 1918

James J. Jones

James J. Jones

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14284

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 7 Film 276 12-16-60 et

14315

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville d. STREET ADDRESS 2263 Hannon St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine First M Middle Williams Last		4. DATE OF DEATH Month Dec. Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1874
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	11. BIRTHPLACE (State or foreign country) Clarksville Ark.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Clifton Williams	
14. MOTHER'S MAIDEN NAME Mollie Gaffney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —	
16. SOCIAL SECURITY NO. —		17. INFORMANT Ms. Edward J. Davis, Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 26 19 60 to Dec. 7 19 60 , that (I) (we) last saw the deceased alive on Dec. 6 19 60 , and that death occurred at 8:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sanford H. Eisenberg		22b. DATE SIGNED 12/8/60	
22c. PHYSICIAN'S NAME (Type) SANFORD H. EISENBERG		22d. ADDRESS 1918 K ST N.W. Washington 6 D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/60	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town, or county) (State) mt. Rainier, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 12 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

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U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D. C.

June 1, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of May 28, 1914, in relation to the matter of the proposed amendment to the regulations governing the sale of seedling stock.

The matter is being considered by the Department and a decision will be rendered as soon as possible.

Very respectfully,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

Very truly yours,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

Very truly yours,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

Very truly yours,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

Very truly yours,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

Very truly yours,
Assistant Secretary

Enclosed for you are two copies of the proposed amendment to the regulations governing the sale of seedling stock.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

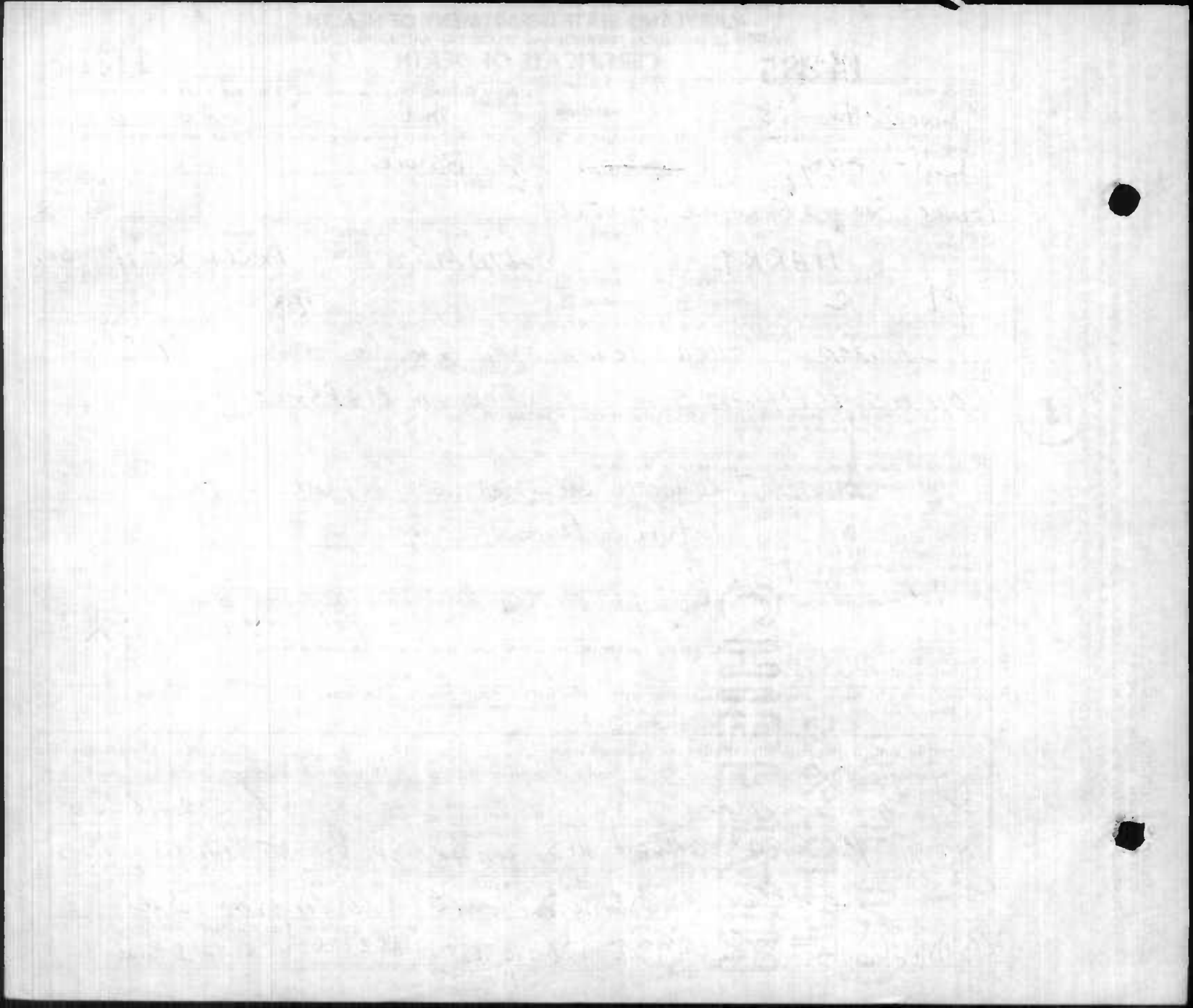
14285

Item 7 Film G278 1-4-61 et

14316

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bowie</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First Middle Last 4. DATE OF DEATH <u>December 18</u> 19 <u>60</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>74</u> yrs. 9. AGE (In years lost birthday) <u>74</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Road Comm.</u> 11. BIRTHPLACE (State or foreign country) <u>Pr. Geo. Co Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Thomas Williams</u> 14. MOTHER'S MAIDEN NAME <u>Morish Mathews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u></u> Address <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOTIC OCCLUSION, LEFT INT. CAROTID ART</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12-18-60</u> to <u>12-18-60</u> , that (I) (we) last saw the deceased alive on <u>12-18-60</u> , and that death occurred at <u>12-18-60</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Irvin M. Grassgreen</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>IRVIN M. GRASSGREEN, M.D.</u> 22d. ADDRESS <u>3101 ARUNDEL RD. MT. RAINIER, MD.</u> 22b. DATE SIGNED <u>12-18-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-22-60</u> 23b. DATE THEREOF <u>12-22-60</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat</u> 23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington</u> ADDRESS <u>452 4925 Deane Rd</u> 25a. REC'D BY REGISTRAR <u>DEC 27 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>	

10K



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

14286

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14317

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle P Last Willmuth				4. DATE OF DEATH Month Dec. Day 25 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 June 1872	
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Housewife		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles M. Obold				14. MOTHER'S MAIDEN NAME Ella E. Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John P.H. Willmuth Same As # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intestinal hemorrhage 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 21 19 60 to Dec. 25 19 60 , that (I) (we) last saw the deceased alive on Dec. 21 19 60 , and that death occurred at 4.00A from the causes and on the date stated above.							
22a. SIGNATURE Donald W. Mitchell				22b. DATE SIGNED 12-25-60		22c. PHYSICIAN'S NAME (Type) Dr. Donald Mitchell., Md	
22d. ADDRESS 1746 K St. N.W. Washington D.C.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/60		23c. NAME OF CEMETERY OR CREMATORY St. Joseph		23d. LOCATION (City, town, or county) (State) Hanover Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Co. 517 11th St. S.E. Wash. D.C.				25a. REC'D BY REGISTRAR DATE DEC 29 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Travis	

CERTIFICATE OF DEATH

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Thomas A. ...

CHIEF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14318

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 605 8th St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wong See Wing		4. DATE OF DEATH Month 12 Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE Chinese	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/96
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (?)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) China		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wong Tom Fork		14. MOTHER'S MAIDEN NAME Hu ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular accident, probably embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active (4 months); right empyema, mixed infection; diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 802x	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/25 1:00 1960 to 12/14 1960, that (I) (we) last saw the deceased alive on 12/14 1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE 12/14/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 12/16/60	
23c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Moe Weiss and Glenn Dale, Md.		25a. REC'D BY REGISTRAR DATE DEC 20 60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

14287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14319

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4007 Metzertott Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maybelle A Wiseman		4. DATE OF DEATH Month Day Year Dec. 7 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1885
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Daniel Cratty		14. MOTHER'S MAIDEN NAME Mary White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daniel Wiseman		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446X IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO Uremia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Right pyonephrosis DUE TO Arteriolar nephrosclerosis, bilateral (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to Dec. 7 1960 , that (I) (we) last saw the deceased alive on 19 60 , and that death occurred at 12:15 P.M. from Me causes and on the date stated above.			
22a. SIGNATURE Dr. Chas. David Connors, M.D.		22b. ADDRESS 5813 Landover Road, Cheverly, Md.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 10, 1960	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR DEC 14 '60	
ADDRESS Hyattsville, Md		25b. REGISTRAR'S SIGNATURE Cashin S. K...	

14387

UNITED STATES OF AMERICA

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

AND

MINES

FOR THE YEAR 1900

AND

FOR THE YEAR 1901

AND

FOR THE YEAR 1902

AND

FOR THE YEAR 1903

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FOR THE YEAR 1904

AND

FOR THE YEAR 1905

AND

FOR THE YEAR 1906

CERTIFICATE OF DEATH

Reg. Dist. No.

14320

14288

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2216 Cheverly Avenue		d. STREET ADDRESS 2216 Cheverly Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle H. Last Woodward		4. DATE OF DEATH Month December Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Mason Heidwohl		14. MOTHER'S MAIDEN NAME Martha E. Littleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nannie G Littleton		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs + 5 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour a. s. m. - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from Aug. , 19 59 , to 12/10 , 19 60 , that I last saw the deceased alive on 12/9 , 19 60 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3501 Hamilton St Hyt. DATE SIGNED 12/10/60 ACTUAL SIGNATURE Frank M Trozzo Jr M.D. PHYSICIAN'S NAME (Type) FRANK M TROZZO JR HYATTSTVILLE-MD-			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/60	
22c. NAME OF CEMETERY OR CREMATORY Edgehill Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DEC 14 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Kinn			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Route #301		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Estelle Wyvill		4. DATE OF DEATH Month December Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Andrew Schultz		14. MOTHER'S MAIDEN NAME Alice King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Samuel A. Wyvill		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 47 , to 28 Mar , 19 60 that I last saw the deceased alive on 28 Mar , 19 60 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Sasscer		DATE SIGNED 28 Mar 60	
PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.		ADDRESS (Street, city or town, state) Upper Marlboro, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/30/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home		24a. REC'D BY REGISTRAR 3 '61	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Edna E. Foster	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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No. 1234

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14322

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5801 42nd Ave		d. STREET ADDRESS 1460-Irving Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William L. Middle Yates Last		4. DATE OF DEATH Month December 22 Day 1960 Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 15.1877	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Taxi driver		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Yates		14. MOTHER'S MAIDEN NAME Virginia Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Claude Spitzer Step son Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerular Nephritis S92X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/25 19 60 , to 12/23 19 60 , that (I) (was) last saw the deceased alive on 12/21 19 60 , and that death occurred at 9:59 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Harold F. M. Cann		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HAROLD F. M. CANN		22d. ADDRESS 3355-16th N.W. Wash. 10, D.C.			
23a. BURIAL, CREMATION, OR REMOVAL RECORD 12/24/60		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
23d. LOCATION (City, town, or county) (State) Suitland, Md.		23e. REC'D BY REGISTRAR DEC 27 '60		23f. REGISTRAR'S SIGNATURE Arthur L. Hume	
24. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co. 300-4th Street N.E.					

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